

- ▶ Test your clinical judgment with a NCLEX Next Generation-style question: [Chapter 9, Assignment 1](#)⁴



- ▶ Test your clinical judgment with a NCLEX Next Generation-style case study: [Chapter 9, Case Study 1](#)⁵



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IX Glossary

Agoraphobia: Intense fear of two or more of the following situations: using public transportation, being in open spaces (e.g., parking lots, marketplaces, or bridges), being in enclosed spaces (e.g., shops or theaters), standing in line or being in a crowd, or being outside of the home alone.

Anxiety: A universal human experience that includes feelings of apprehension, uneasiness, uncertainty, or dread resulting from a real or perceived threat.

Compulsions: Repetitive behaviors that a person with OCD feels the urge to do in response to an obsessive thought.

Coping strategies: An action, a series of actions, or a thought process used to address a stressful or unpleasant situation or modify one's reaction to such a situation.

Defense mechanisms: Reaction patterns used by individuals to protect themselves from anxiety that arises from stress and conflict.

Dialectal behavioral therapy (DBT): A structured, evidence-based psychotherapy that combines cognitive-behavioral techniques for emotion regulation and reality-testing with concepts of mindfulness, acceptance, and dialectics (the idea that two seemingly opposite things can both be true).

Exposure and response prevention (EX/RP): A type of psychotherapy effective in reducing compulsive behaviors in clients with OCD. EX/RP includes spending time in the very situation that triggers compulsions (for example, touching dirty objects) but then being prevented from undertaking the usual resulting compulsion (handwashing).

Exposure therapy: A type of psychotherapy that focuses on confronting the fears underlying an anxiety disorder to help people engage in activities they have been avoiding.

Generalized anxiety disorder (GAD): Excessive anxiety and worry occurring

for at least six months about a number of events or activities (such as work or school performance).

Obsessions: Repeated thoughts, urges, or mental images that cause anxiety.

Obsessive-compulsive disorder (OCD): A common chronic disorder in which a person has uncontrollable, reoccurring thoughts (obsessions) and/or behaviors (compulsions) they feel the urge to repeat over and over. Performing the compulsive behaviors often brings the person brief relief from the anxiety the obsessive thoughts cause them.

Panic: The most extreme level of anxiety that results in significantly dysregulated behavior. The individual is unable to process information from the environment and may lose touch with reality.

Panic attacks: Sudden periods of intense fear that come on quickly and reach their peak within minutes. Attacks can occur unexpectedly or can be brought on by a trigger, such as a feared object or situation.

Phobia: An intense fear or aversion to specific objects or situations (e.g., flying, heights, animals, receiving an injection, or seeing blood).

Post-traumatic stress disorder (PTSD): A disorder that develops in some people who have experienced a shocking, frightening, or dangerous event where they feel stressed or frightened even when they are not in danger.

Repetitive Transcranial Magnetic Stimulation (rTMS): Treatment that uses a magnet to activate specific sites in the brain.

Selective mutism: A condition when people fail to speak in specific social situations despite having normal language skills.

Separation anxiety disorder: A condition where an individual has a fear about being separated from people to whom they are attached.

Social anxiety disorder: Significant fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others.

Learning Objectives

- Identify assessment cues of personality disorder behaviors
- Identify nursing priorities for clients with personality disorders
- Plan outcomes for clients with personality disorders
- Differentiate safety/protective interventions for clients with personality disorders
- Apply evidence-based practice when planning care and interventions for clients with personality disorders
- Analyze treatments for clients with personality disorders
- Apply the nursing process to clients with personality disorders at risk for suicide

Research studies have demonstrated that nine percent of Americans have a personality disorder. A large proportion of this population is also diagnosed with one or more other mental illnesses.¹ This chapter will describe the signs and symptoms of ten personality disorders and associated treatments.

1. National Institute of Mental Health. (n.d.). *Personality disorders*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/statistics/personality-disorders>

10.2 Basic Concepts

A person's **personality** is a relatively stable pattern of thinking, feeling, and behaving that evolves over their lifetime. It is unique to each individual and influenced by their experiences, environment (surroundings and life situations), and inherited characteristics. **Personality traits** are characteristics, whether considered positive or negative, that make up one's personality. Healthy personality traits include characteristics such as the following:

- Demonstrating healthy personal boundaries
- Accepting responsibility for personal actions
- Communicating in a healthy and effective manner
- Obeying laws
- Showing mutual respect in relationships
- Being independent
- Displaying confidence
- Behaving in a non-impulsive manner

Review healthy personal boundaries in the “[Foundational Mental Health Concepts](#)” chapter. An individual's personality is considered unhealthy and classified as a disorder when it impacts their interpersonal relationships and results in impaired functioning in social, occupational, or other important areas of their life.¹

The *Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR)* defines a **personality disorder** as an enduring pattern of inner experience and behavior that deviates significantly from the expectations of the individual's culture. Its onset can be traced back to adolescence or early

1. American Psychiatric Association. (2013). *Desk reference to the diagnostic criteria from DSM-5*.

adulthood and is present in a variety of contexts. This abnormal pattern of behavior is manifested in two or more of the following areas²:

- Cognition (i.e., ways of perceiving and interpreting self, other people, and events)
- Affect (i.e., the range, intensity, lability, and appropriateness of emotional response)
- Interpersonal functioning
- Impulse control

There are ten different personality disorders that are categorized into three clusters (A, B, and C) in the *DSM-5-TR*. Personality disorders within each cluster have similar patterns of behavior. The ten disorders include Cluster A (paranoid, schizoid, schizotypal), Cluster B (antisocial, narcissistic, borderline, histrionic), and Cluster C (dependent, avoidant, and obsessive-compulsive personality disorder).³ These disorders are often **ego-syntonic**, meaning that the behaviors and thoughts are consistent with the individual's self-perception and are not seen as problematic by the individual, despite causing significant issues in their life.

Each personality disorder is further described in the following sections. As you read through each section, keep in mind that these disorders are more than just personality traits; they are diagnosed based on patterns of behaviors that significantly impair a person's functioning.

Cluster A Personality Disorders

Cluster A personality disorders include paranoid personality disorder,

2. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

3. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

schizoid personality disorder, and schizotypal personality disorder. Cluster A is characterized as the odd, eccentric cluster. Individuals with these types of disorders often experience social awkwardness.

Paranoid Personality Disorder

The *DSM-5-TR* defines **paranoid personality disorder** as a pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning in early childhood and present in a variety of contexts. It is diagnosed in individuals with four or more of the following characteristics⁴:

- Suspects without evidence that others are exploiting, harming, or deceiving them
- Preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates
- Reluctant to confide in others because of unwarranted fear that the information will be used maliciously against them
- Reads hidden meaning or threatening meanings into benign remarks or events
- Persistently bears grudges (i.e., is unforgiving of insults, injuries, or slights)
- Perceives attacks on their character or reputation that are not apparent to others and is quick to react angrily or to counterattack
- Has recurrent suspicions without justification regarding fidelity of spouse or sexual partner

See Figure 10.1⁵ for a word cloud image representing paranoid personality disorder.

4. American Psychiatric Association. (2013). *Desk reference to the diagnostic criteria from DSM-5*.

5. “[Word_Cloud_PPD.png](#)” by [MissLunaRose12](#) is licensed under [CC BY-SA 4.0](#)

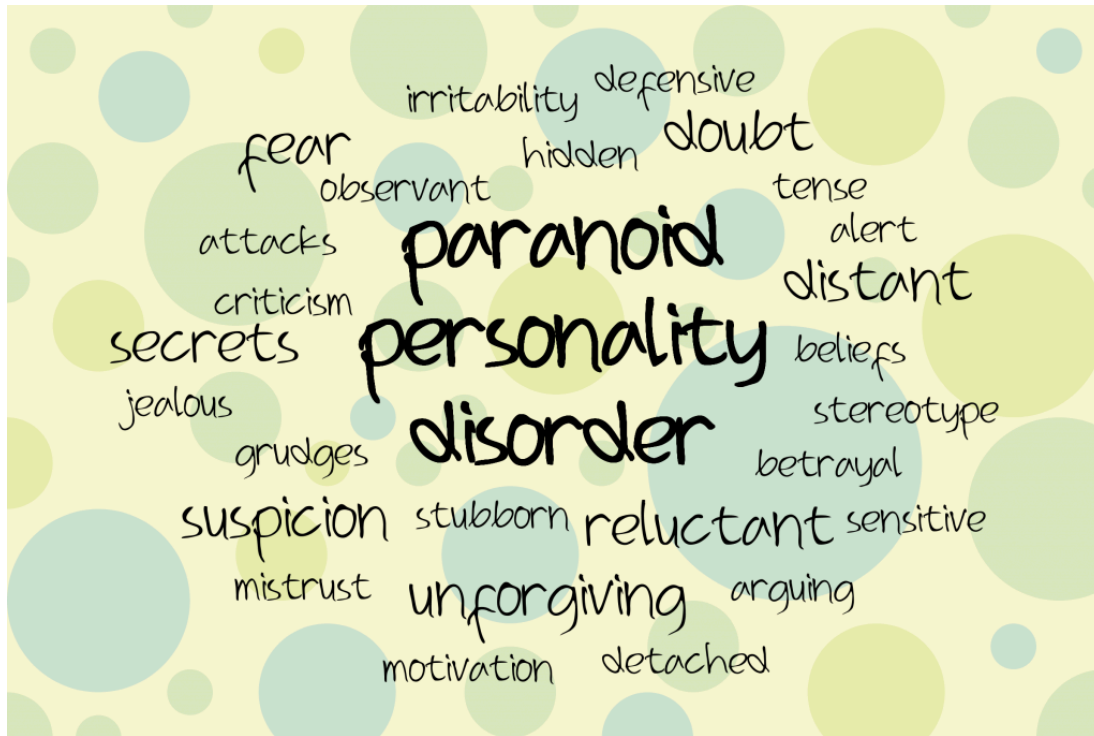


Figure 10.1 Paranoid Personality Disorder

Schizoid Personality Disorder

The *DSM-5-TR* defines **schizoid personality disorder** as a pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning in early childhood and present in a variety of contexts. It is diagnosed in individuals with four or more of the following characteristics⁶:

- Neither desires nor enjoys close relationships including being part of a family
- Almost always chooses solitary activities
- Has little, if any, interest in having sexual experiences with another person
- Takes pleasure in few, if any, activities
- Lacks close friends other than first-degree relatives

6. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

- Appears indifferent to the praise or criticism of others
- Shows emotional coldness, detachment, or flat affect

See Figure 10.2⁷ for a word cloud image representing schizoid personality disorder.



Figure 10.2 Schizoid Personality Disorder

Schizotypal Personality Disorder

The *DSM-5* defines **schizotypal personality disorder** as a pervasive pattern of social and interpersonal deficits marked by acute discomfort with and reduced capacity for close relationships, as well as by cognitive or perceptual distortions and eccentricities of behavior, beginning in early adulthood and

7. “Word_Cloud_SzPD.png” by [MissLunaRose12](#) is licensed under [CC BY-SA 4.0](#)

present in a variety of contexts. It is diagnosed in individuals with five or more of the following characteristics⁸:

- **Ideas of reference** (i.e., the false belief that coincidental events relate to oneself). For example, a person shopping in a store sees two strangers laughing and believes that they are laughing at them, when, in reality, the other two people do not even notice them.
- Odd beliefs or magical thinking that influence behavior and are inconsistent with cultural norms (**Magical thinking** refers to the idea that one can influence the outcome of specific events by doing something that has no bearing on the circumstances. For example, a person watching a baseball game exhibits magical thinking when believing that holding the remote control in a certain position caused their favorite player to hit a home run.)
- Unusual perceptual experiences including bodily illusions (A **body illusion** refers to a perception that one's body is significantly different from its actual configuration. For example, a person lying in bed feels as if they are levitating.)
- Odd thinking and speech
- Suspiciousness or paranoid ideation
- Inappropriate or constricted affect
- Behavior or appearance that is odd, eccentric, or peculiar
- Lack of close friends or confidants other than first-degree relatives
- Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self

Please Note: There are key differences between the schizotypal and schizoid. Schizoid is marked by social detachment and emotional coldness without

8. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

cognitive or perceptual distortions, whereas schizotypal includes these social deficits along with cognitive or perceptual distortions and eccentric behavior.

See Figure 10.3⁹ for a word cloud image representing schizotypal personality disorder.



Figure 10.3 Schizotypal Personality Disorder

Cluster B Personality Disorders

Cluster B personality disorders include antisocial, borderline, histrionic, and narcissistic personality disorders. Cluster B personality disorders are characterized by dramatic, overly emotional, or unpredictable thinking or behavior.

Antisocial Personality Disorder

The *DSM-5-TR* defines **antisocial personality disorder** as a pervasive pattern

9. “[Word_Cloud_StPD.png](#)” by [MissLunaRose12](#) is licensed under [CC BY-SA 4.0](#)

of disregard for and violation of the rights of others since age 15. It is diagnosed in individuals with three or more of the following characteristics^{10]}:

- Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest
- Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
- Impulsivity or failure to plan ahead
- Irritability and aggressiveness, as indicated by repeated physical fights and assaults
- Reckless disregard for the safety of self or others
- Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
- Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another person

See Figure 10.4^{11]} for a word cloud image representing antisocial personality disorder.

10. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

11. “[Word_Cloud_AsPD.png](#)” by [MissLunaRose12](#) is licensed under [CC BY-SA 4.0](#)



Figure 10.4 Antisocial Personality Disorder

Borderline Personality Disorder

The *DSM-5-TR* defines **borderline personality disorder** as a pervasive pattern of instability of personal relationships, self-image, and affect with significant impulsivity, beginning in early adulthood and present in a variety of contexts. It is diagnosed in individuals with five or more of the following characteristics¹²:

- Frantic efforts to avoid real or imagined abandonment
- A pattern of unstable and intense personal relationships characterized by alternating between extremes of idealization and devaluation (referred to as **splitting**)
- Identity disturbance with significantly and persistently unstable self-image or sense of self
- Impulsivity in at least two areas that are potentially self-damaging (e.g.,

12. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

- spending, sex, substance misuse, reckless driving, or binge eating)
- Recurrent suicidal behavior or self-mutilating behavior
- Unstable affect with significant mood reactivity (i.e., intense anxiety or irritability usually lasting only a few hours)
- Chronic feelings of emptiness
- Inappropriate, intense anger or difficulty controlling anger
- Transient, stress-related paranoid ideation or severe dissociative symptoms (**Dissociative symptoms** include the experience of detachment or feeling as if one is outside one's body. It is often associated with loss of memory of the experience. Dissociative disorders are associated with an individual's previous experience of trauma.)

See Figure 10.5¹³ for a word cloud image representing borderline personality disorder.



Figure 10.5 Borderline Personality Disorder

13. "Word_Cloud_BPD.png" by [MissLunRose12](#) is licensed under [CC BY-SA 4.0](#)

Histrionic Personality Disorder

The *DSM-5-TR* defines **histrionic personality disorder** as a pervasive pattern of excessive emotionality and attention seeking, beginning in early adulthood and present in a variety of contexts. It is diagnosed in individuals with five or more of the following characteristics¹⁴:

- Uncomfortable in situations in which they are not the center of attention
- Interaction with others is characterized by inappropriate sexually seductive or provocative behavior
- Rapidly shifting and shallow expression of emotion
- Consistently uses physical appearance to draw attention to oneself
- Excessively impressionistic speech that is lacking in detail
- Shows self-dramatization, theatricality, and exaggerated expression of emotion
- Suggestible (i.e., easily influenced by others)
- Considers relationships to be more intimate than they actually are

See Figure 10.6¹⁵ for a word cloud image representing histrionic personality disorder.

14. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

15. “[Word_Cloud_HPD.png](#)” by [MissLunRose12](#) is licensed under [CC BY-SA 4.0](#)

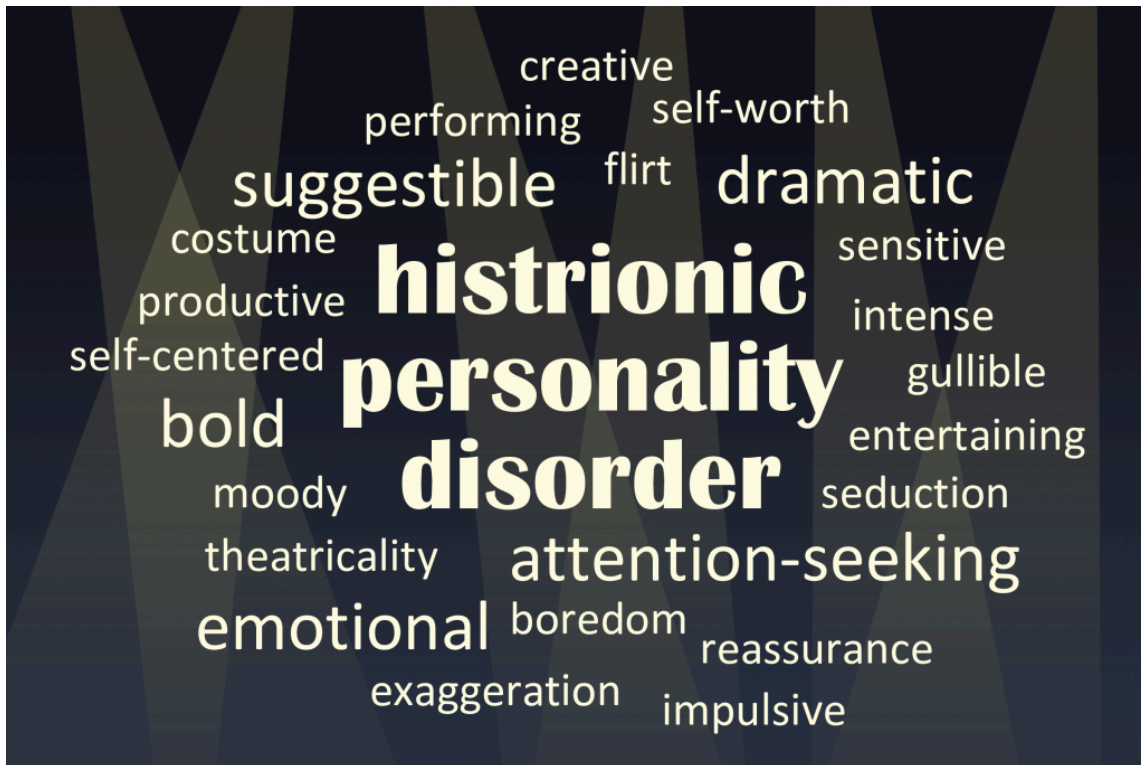


Figure 10.6 Histrionic Personality Disorder

Narcissistic Personality Disorder

The *DSM-5-TR* defines **narcissistic personality disorder** as a pervasive pattern of grandiosity (in fantasy or behavior), need for attention, and lack of empathy, beginning in early adulthood and present in a variety of contexts. It is diagnosed in individuals with five or more of the following characteristics¹⁶:

- Has a grandiose sense of self-importance (i.e., exaggerates achievements and talents)
- Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
- Believes they are “special” and can only be understood by, or should only associate with, other “special” or high-status people (or institutions)
- Requires excessive admiration

16. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

- Has a sense of **entitlement** (i.e., unreasonable expectations of especially favorable treatment)
- Exploits others to achieve their own goals
- Lacks empathy and the ability to identify with the feelings and needs of others
- Is often envious of others or believes that others are envious of them
- Shows arrogant or haughty behaviors or attitudes

See Figure 10.7¹⁷ for a word cloud image representing narcissistic personality disorder.



Figure 10.7 Narcissistic Personality Disorder

Cluster C Personality Disorders

Cluster C personality disorders include avoidant, dependent, and obsessive-

17. “[Word_Cloud_NPD.png](#)” by [MissLunRose12](#) is licensed under [CC BY-SA 4.0](#)

compulsive personality disorders. Cluster C personality disorders are characterized by anxious, fearful thinking or behavior.

Avoidant Personality Disorder

The *DSM-5-TR* defines **avoidant personality disorder** as a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning in early adulthood and present in a variety of contexts. It is diagnosed in individuals with four or more of the following characteristics¹⁸:

- Avoids occupational activities that involve significant interpersonal contact because of fears or criticism, disapproval, or rejection
- Is unwilling to get involved with people unless certain of being liked
- Shows restraint within intimate relationships because of the fear of being shamed or ridiculed
- Is preoccupied with being criticized or rejected in social situations
- Is inhibited in new interpersonal situations because of feelings of inadequacy
- Views self as socially inept, personally unappealing, or inferior to others
- Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing

See Figure 10.8¹⁹ for a word cloud image representing avoidant personality disorders.

18. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

19. “[Word_Cloud_AvPD.png](#)” by [MissLunRose12](#) is licensed under [CC BY-SA 4.0](#)

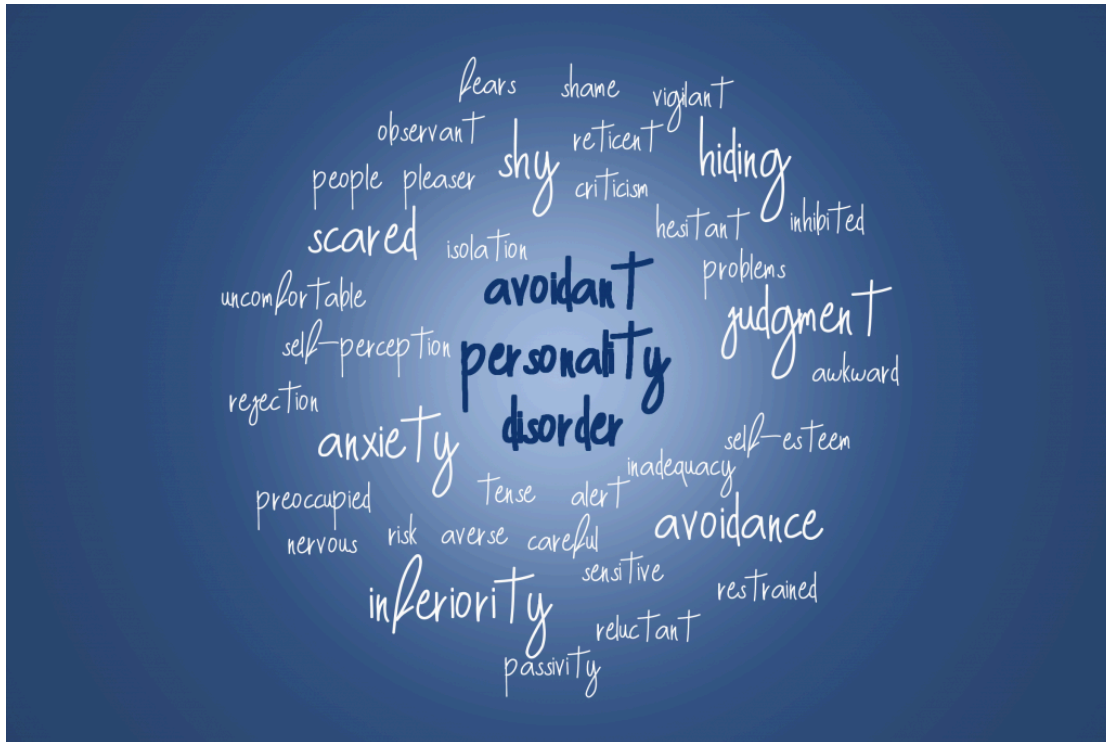


Figure 10.8 Avoidant Personality Disorder

Dependent Personality Disorder

The *DSM-5-TR* defines **dependent personality disorder** as a pervasive and excessive need to be taken care of that leads to submission and clinging behavior and fears of separation, beginning in early childhood and present in a variety of contexts. It is diagnosed by five or more of the following characteristics²⁰:

- Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others
- Needs others to assume responsibility for most major areas of their life
- Has difficulty expressing disagreement with others because of fear of loss or support or approval
- Has difficulty initiating projects or doing things on their own because of lack of self-confidence in judgment or abilities

20. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

- See Figure 10.9²¹ for a word cloud image representing dependent personality disorder.



The *DSM-5-TR* defines **obsessive-compulsive personality disorder** as a

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pervasive pattern or preoccupation with orderliness, perfectionism, and mental and interpersonal control at the expense of flexibility, openness, and efficiency, beginning in early childhood and present in a variety of contexts. It is diagnosed in individuals with four or more of the following characteristics²²:

- Is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost
- Shows perfectionism that interferes with task completion (i.e., is unable to complete a project because their overly strict standards are not met)
- Is excessively devoted to work and productivity to the exclusion of leisurely activities and friendships
- Is overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification)
- Is unable to discard worn-out or worthless objects even when they have no sentimental value
- Is reluctant to delegate tasks or work with others unless they submit to exactly their way of doing things
- Adopts a miserly spending style towards self and others; money is viewed as something to be hoarded for future catastrophes
- Shows rigidity and stubbornness

It is important to note that obsessive-compulsive personality disorder (OCPD) is a different disorder than obsessive-compulsive disorder (OCD). OCPD includes long-term personality traits characterized by extreme perfectionism, rigidity, and adherence to rules. A person with OCPD is often proud of these personality traits. Conversely, OCD includes uncontrollable, recurring thoughts (obsessions) and/or behaviors (compulsions) that cause the individual significant emotional distress.

22. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

- ▶ Review the “[Obsessive-Compulsive Disorder](#)” section of the “Anxiety Disorders” chapter for more details about obsessive-compulsive disorder.

See Figure 10.10²³ for a word cloud image representing obsessive-compulsive personality disorder.

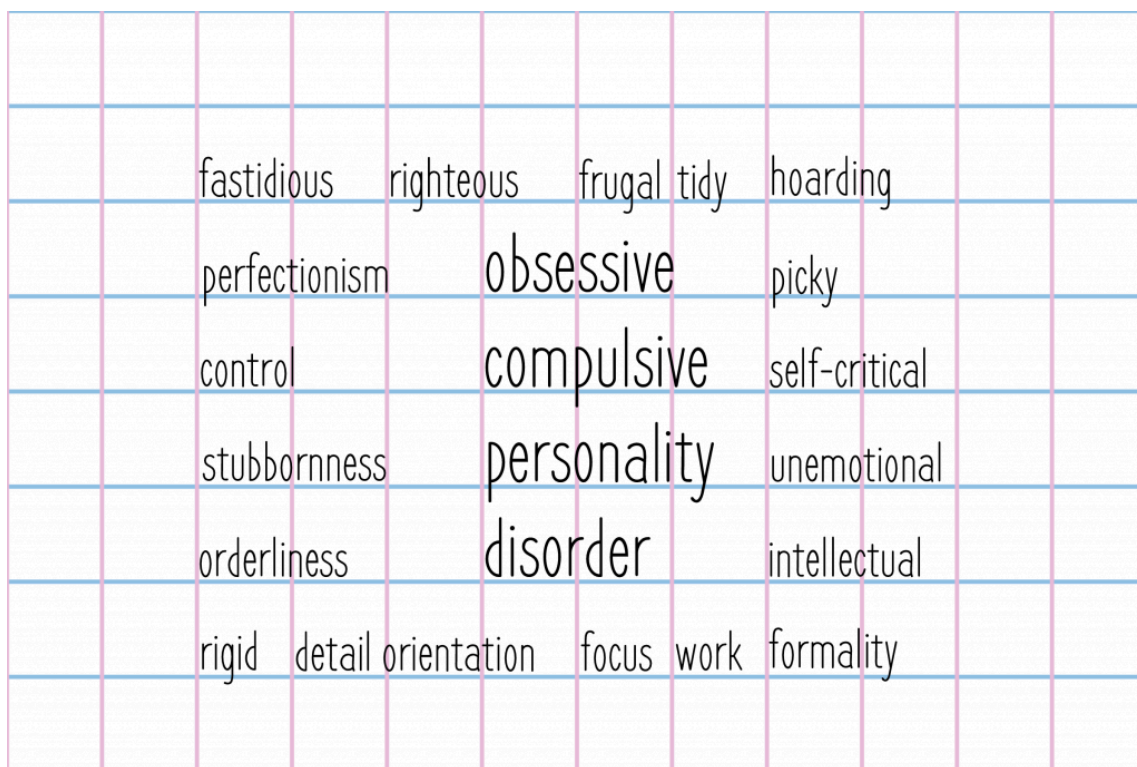


Figure 10.10 Obsessive-Compulsive Personality Disorder

23. “[Word_Cloud_OCPD.png](#)” by [MissLunRose12](#) is licensed under [CC BY-SA 4.0](#)



View the following Khan Academy YouTube video explaining personality disorders²⁴ : [Personality Disorders](#).

Reflective Question:

1. When does one's personality become a disorder versus just personality traits?

Risk Factors for Personality Disorders

Research suggests that genetics, childhood trauma, peer influences, and other factors can contribute to the development of personality disorders.^{25,26}

- **Adverse Childhood Experiences (ACEs):** Multiple studies have shown that childhood adversities such as emotional, physical, and sexual abuse,

24. khanacademymedicine. (2015, July 20). *Personality disorders | Behavior | MCAT | Khan Academy* [Video]. YouTube. All rights reserved.
<https://youtu.be/-Xv593jgyJ4>

25. American Psychological Association (2010). *What causes personality disorders?* <https://www.apa.org/topics/personality-disorders/causes>

26. Solmi, M., Dragioti, E., Croatto, G., Radua, J., Borgwardt, S., Carvalho, A. F., Demurtas, J., Mosina, A., Kurotschka, P., Thompson, T., Cortese, S., Shin, J. I., & Fusar-Poli, P. (2021). Risk and protective factors for personality disorders: An umbrella review of published meta-analyses of case-control and cohort studies. *Front Psychiatry*, 12, 679379. [doi:10.3389/fpsy.2021.679379](https://doi.org/10.3389/fpsy.2021.679379).

as well as neglect, significantly increase the risk of developing personality disorders. For instance, childhood emotional abuse and neglect have been strongly associated with borderline personality disorder (BPD).²⁷

- **Perinatal Complications:** Factors such as prematurity, asphyxia, and complicated deliveries have been linked to an increased risk of personality disorders. These perinatal complications may lead to abnormal brain development, which can predispose individuals to personality pathology.²⁸
- **Prenatal Stress:** Exposure to maternal stress during pregnancy has been associated with a higher likelihood of developing personality disorders in offspring. This association remains significant even after adjusting for other factors such as parental psychiatric history and prenatal smoking.²⁹
- **Childhood Behavioral Problems:** Early conduct problems, depressive symptoms, anxiety, and immaturity have been identified as predictors of personality disorders in adolescence and adulthood. Conduct problems, in particular, have been shown to be an independent predictor across all clusters of personality disorders.³⁰

27. Broekhof, R., Nordahl, H. M., Eikenæs, I. U., & Selvik, S. G. (2024). Adverse childhood experiences are associated with personality disorder: A prospective, longitudinal study. *Journal of Personality Disorders*, 38(1), 19-33. doi: [10.1521/pedi.2024.38.1.19](https://doi.org/10.1521/pedi.2024.38.1.19).
28. Fazel, S., Bakiyeva, L., Cnattingius, S., Grann, M., Hultman, C. M., Lichtenstein, P., & Geddes, J. R. (2012). Perinatal risk factors in offenders with severe personality disorder: A population-based investigation. *Journal of Personality Disorders*, 26(5), 737-50. doi: [10.1521/pedi.2012.26.5.737](https://doi.org/10.1521/pedi.2012.26.5.737).
29. Brannigan, R., Tanskanen, A., Huttunen, M. O., Cannon, M., Leacy, F. P., & Clarke, M. C. (2020). The role of prenatal stress as a pathway to personality disorder: Longitudinal birth cohort study. *The British Journal of Psychiatry*, 216(2), 85-89. doi: [10.1192/bjp.2019.190](https://doi.org/10.1192/bjp.2019.190).
30. Bernstein, D. P., Cohen, P., Skodol, A., Bezirgianian, S., & Brook, J. S. (1996).

- **Genetic and Temperamental Factors:** Certain temperamental traits, such as high neuroticism and low agreeableness, have been implicated in the development of personality disorders. These traits can interact with environmental factors to increase the risk.^{31,32}
- **Invalidating Relational Experiences:** Maladaptive parenting, problematic peer relationships, and other invalidating experiences during childhood and adolescence can contribute to the development of personality disorders, particularly.³³

Certain positive factors can help prevent children from developing personality disorders. For example, a single strong relationship with a relative, teacher, or friend can offset negative influences. Strong resiliency factors contribute to the health and development of a child.³⁴

Childhood antecedents of adolescent personality disorders. *American Journal of Psychiatry*, 153(7), 907-13. doi: 10.1176/ajp.153.7.907.

31. American Psychological Association (2010). *What causes personality disorders?* <https://www.apa.org/topics/personality-disorders/causes>
32. Junewicz, A., & Billick, S. B. (2021). Preempting the development of antisocial behavior and psychopathic traits, *The Journal of American Academy of Psychiatry Law*, 49(1), 66-76. <https://doi10.29158/JAAPL.200060-20>
33. Solmi, M., Dragioti, E., Croatto ,G., Radua, J., Borgwardt, S., Carvalho, A.F., Demurtas, J., Mosina, A., Kurotschka, P., Thompson, T., Cortese, S., Shin, J. I., & Fusar-Poli, P. (2021). Risk and protective factors for personality disorders: An umbrella review of published meta-analyses of case-control and cohort studies. *Front Psychiatry*, 12, 679379. doi: 10.3389/fpsyt.2021.679379.
34. American Psychological Association (2010). *What causes personality disorders?* <https://www.apa.org/topics/personality-disorders/causes>

10.3 Treatment for Personality Disorders

Clients with some types of personality disorders do not exhibit insight for their condition and are unlikely to seek treatment. They often go undiagnosed unless they seek treatment for another psychiatric or medical diagnosis. Some may also be forced to seek treatment at the influence of family members or as required by law if legal infractions have occurred. Personality disorders can be challenging for mental health professionals to treat. Individuals with personality disorders struggle to recognize that their difficulties in life are related to their personalities. They may truly believe their problems are a result of other people or outside factors which makes treatment difficult. It is very common for clients with personality disorders to also have substance abuse, anxiety, depression, or eating disorders.¹

Treatment for personality disorders is tailored to the specific disorder and individual client needs, and it is a gradual process. Psychotherapy is the first line of treatment for personality disorders. Medications may also be prescribed to treat underlying co-occurring conditions such as anxiety or depression.

Psychotherapy

During psychotherapy, an individual can gain insight and knowledge about the personality disorder and what is contributing to their symptoms. They talk about their thoughts, feelings, and behaviors and ideally will develop an understanding of the impact of their thoughts and behaviors on themselves and others. They learn strategies for managing and coping with their symptoms. This treatment can help reduce problematic behaviors that impact an individual's relationships and functioning.²

1. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.
2. American Psychiatric Association. (n.d.). *What are personality disorders?*

Common types of psychotherapy used to treat personality disorders are as follows³:

- Cognitive behavior therapy
- Dialectical behavior therapy
- Interpersonal therapy
- Psychoanalytic/psychodynamic therapy
- Psychoeducation

Cognitive behavior therapy (CBT) teaches the client to become more aware of the way they think so they can ultimately change the way they behave.

Dialectical behavior therapy (DBT) is a type of cognitive behavioral therapy that was originally created for clients with borderline personality disorder to help them cope with stress, control emotions, and establish healthy relationships. It is considered the gold standard for treating borderline personality disorder and is also used for other types of disorders. The client learns how to be aware of how thoughts, feelings, behaviors link together. They learn how to use their senses to be aware of what is happening around them and how to use strategies (such as mindfulness, distress tolerance, interpersonal effectiveness, and emotion regulation) to react calmly in a crisis, avoid negative impulsive behavior, and improve relationships.⁴ See Figure

<https://www.psychiatry.org/patients-families/personality-disorders/what-are-personality-disorders>

3. American Psychiatric Association. (n.d.). *What are personality disorders?* <https://www.psychiatry.org/patients-families/personality-disorders/what-are-personality-disorders>
4. Schimelpfening, N. (2021). What is dialectical behavior therapy (DBT)? *Verywell Mind*. <https://www.verywellmind.com/dialectical-behavior-therapy-1067402>

10.11⁵ for an illustration of how thoughts, feelings and behaviors are linked together.

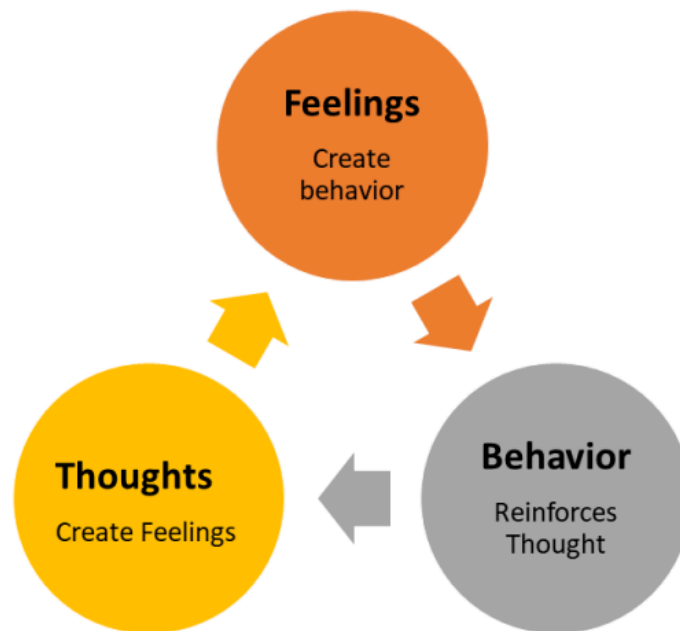


Figure 10.11 Dialectical Behavior Therapy

Interpersonal therapy focuses on developing healthy relationships with others. Negative aspects of relationships, such as social isolation and aggression, are identified, and strategies to improve relationships are discussed and planned.

Psychodynamic therapy promotes self-reflection and self-examination of problematic relationship patterns and unresolved conflicts. It can bring awareness of how one's past has an influence on one's present behavior.

Mentalization-Based Therapy: A type of psychotherapy designed to help individuals improve their ability to understand and interpret their own and others' mental states—such as thoughts, feelings, and intentions. The goals

5. "Dialectical Behavior Therapy by Kim Ernstmeier.png" by Kim Ernstmeier for [Chippewa Valley Technical College](#) is licensed under [CC BY 4.0](#)

are to improve self-awareness and understanding of one's own emotions, enhance empathy and understanding of others' perspectives. This subsequently helps individuals develop better interpersonal skills and communication.

Psychoeducation teaches the client about their medications, psychotherapies, and support groups available in the community. Wraparound services may be planned with an individualized plan of care that brings multiple services/supports together for the client.

Pharmacotherapy

There are no specific medications approved to treat personality disorders. However, clients may be prescribed medications by their health care provider as adjunctive treatment to psychotherapy. Medications that can be fatal in overdose should be avoided or used with caution. Benzodiazepines can be especially toxic when combined with alcohol or opioids, and they can also cause behavioral disinhibition in clients with personality disorders.⁶

The following medications may be prescribed for symptoms associated with personality disorders: commonly used to treat them include the following⁷:

- Cognitive-perceptual symptoms (e.g., hallucinations and paranoid ideation): Treated with low-dose antipsychotics such as aripiprazole, risperidone, and quetiapine.
- Impulsive behaviors (e.g., self-injury, theft, interpersonal conflict): Impulsivity and behavioral dysregulation may be treated with mood stabilizers (such as valproate and lamotrigine).
- Affective dysregulation (e.g., depressed mood, mood lability, anxiety,

6. Nelson, K. J. (2024). Personality disorders: Overview of pharmacotherapy. *UpToDate*. <https://www.uptodate.com>

7. Nelson, K. J. (2024). Personality disorders: Overview of pharmacotherapy. *UpToDate*. <https://www.uptodate.com>

anger): Treated with mood stabilizers and low dose antipsychotics, which are more effective than antidepressants in this population.

Support Groups

Support groups and supportive relationships can be helpful for sharing experiences with others who are going through similar situations. Talking with trusted friends or family members can also provide emotional support and encouragement.

10.4 Applying the Nursing Process to Personality Disorders

The nursing process is crucial in the care of patients with personality disorders due to its structured and systematic approach that ensures comprehensive and individualized care.

Assessment (Recognize Cues)

As previously discussed in this chapter, there are ten different personality disorders that are categorized into three clusters (A, B, and C) in the DSM-5. Personality disorders within each cluster have similar patterns of behavior. Cluster A personality disorders include paranoid personality disorder, schizoid personality disorder, and schizotypal personality disorder. Cluster A is characterized as the odd, eccentric cluster. Individuals with these types of disorders often experience social awkwardness. Cluster B personality disorders include antisocial, borderline, histrionic, and narcissistic personality disorders. Cluster B personality disorders are characterized by dramatic, overly emotional, or unpredictable thinking or behavior. Cluster C personality disorders include avoidant, dependent, and obsessive-compulsive personality disorders. Cluster C personality disorders are characterized by anxious, fearful thinking or behavior. Furthermore, personality disorders are often ego-syntonic, meaning that the behaviors and thoughts are consistent with the individual's self-perception and are not seen as problematic by the individual.

Assessing a client with a personality disorder focuses on both verbal and nonverbal assessments. As the nurse conducts follow-up assessments, findings are compared to baseline admission assessments. Assessment includes several components, such as a mental status examination, psychosocial assessment, cultural assessment, spiritual assessment, screening with validated tools, and review of laboratory testing results while also considering lifespan considerations. Review information about performing a mental status examination and psychosocial assessment in the [“Application of the Nursing Process in Mental Health Care”](#) chapter.

Mental Status Examination

See Table 10.4a for common themes when assessing a client with a personality disorder. Review information about a mental status examination in the “[Assessment](#)” section in Chapter 4.

Table 10.4a Common Findings During A Mental Status Examination Of A Client With A Personality Disorder

Mental Status Examination Component	Common Themes in Personality Disorders
Signs of Distress	Clients with personality disorders may have suicidal ideation, perform self-harm like cutting, or have violence or homicidal ideation. *Increased risk for self-injury, suicide, or injury to others must be promptly reported to provider. Do not leave clients alone if statements such as these are being made.
Level of Consciousness and Orientation	Clients with personality disorders are typically alert and oriented to person, place, time, and situation. Cognitive functioning is typically intact unless complicated by comorbid conditions or dissociative episodes
Appearance and General Behavior	Behaviors varies by type of personality disorder. Clients may display anger, anxiety, hypersensitivity, emotional lability, or detachment. Behavior may appear dramatic, guarded, rigid, seductive, or odd depending on the subtype. Poor eye contact or unusual mannerisms may be seen in cluster A disorders. In cluster B, the client may present as flamboyant, provocative, or emotionally labile. For example, individuals with borderline personality disorder (BPD) may show intense distress over perceived rejection. In cluster C, the client may present with anxious behaviors.
Speech	Clients with narcissistic or histrionic traits may dominate conversations or speak in an exaggerated manner. Those with paranoid traits may speak with suspicion or defensiveness.
Motor Activity	Clients with BPD or antisocial traits may appear restless or agitated. Minimal movement may be seen in avoidant or schizoid types due to anxiety or withdrawal.
Mood and Affect	Mood may appear anxious, irritable, dysphoric, or constricted depending on the disorder. Mood is often labile or reactive in cluster B disorders (especially in BPD). Clients with BPD often experience feelings of emptiness, intense feelings of abandonment, extreme mood shifts that occur in a matter of hours or days, intense and unstable relationships impulsive behavior such as reckless driving, unsafe sex, substance use, gambling, overspending, or binge eating.¹
Thought and Perception	Thought processes in clients with personality disorders may be rigid or inflexible. Paranoid ideation or transient dissociation may be present under stress. Clients with schizotypal traits may express magical thinking or odd beliefs.
Attitude and Insight	Attitude may be guarded, defensive, manipulative, seductive, or overly compliant based on the disorder. Insight is often limited; clients may externalize blame and minimize their role in conflicts.

Cognitive Abilities and Level of Judgment	Attention, memory, and abstract thinking are typically intact. However, some may show poor judgment or difficulty with impulse control (such as in BPD or antisocial personality disorders). Cognitive distortions are common across all types.

Psychosocial Assessment

As previously discussed in the “[Application of the Nursing Process in Mental Health Care](#)” chapter, a psychosocial assessment obtains additional subjective data that detects risks and identifies treatment opportunities and resources.²³

- Reason for seeking health care (i.e., “chief complaint”)
- Thoughts of self-harm or suicide (both current and historical)
- Cultural assessment
- Spiritual assessment
- Family dynamics
- Current and past medical history
- Current medications
- History of previously diagnosed mental health disorders
- Previous hospitalizations
- Educational background
- Occupational background
- History of exposure to psychological trauma, violence, and domestic

1. Mayo Clinic. (2024). *Borderline personality disorder*. <https://www.mayoclinic.org/diseases-conditions/borderline-personality-disorder/symptoms-causes/syc-20370237>
2. Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder. (2017). *What is cognitive behavioral treatment?* American Psychological Association. <https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral>
3. Halter, M. (2022). *Varcarolis’ foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

abuse

- Substance use (tobacco, alcohol, recreational drugs, misused prescription drugs)
- Family history of mental illness
- Coping mechanisms
- Functional ability/Activities of daily living

Additional focused questions are used to obtain detailed information used to plan care. The mnemonic PQRSTU can be used to ask questions in an organized fashion. See Table 10.4b for a sample PQRST assessment for clients with a borderline personality disorder and sample responses.

Table 10.4b Sample PQRSTU Questions for Assessing Clients With a Borderline Personality Disorder

PQRSTU	Sample Questions	Sample Client Response
Provocation/ Palliation	“What seems to trigger or worsen your emotional pain or distress? What helps you feel better?”	“It usually starts when I feel like someone is ignoring me or pulling away. I hate being alone—it makes everything worse. Sometimes yelling or cutting makes me feel better, but then I feel ashamed.”
Quality	“Can you describe what your emotional pain feels like?”	“It’s like a storm inside—so intense I can’t control it. One minute I’m fine, the next I’m crying, screaming, or wanting to disappear. It feels like I’m broken or empty.”
Region	“Do you feel any physical symptoms?”	“I feel like I can’t breathe when I get really upset. Sometimes I feel shaky. I’ve had stomachaches or headaches after a fight with my boyfriend.”
Severity	“On a scale of 0 to 10, how intense is your distress when it happens?”	“It’s a 10. I feel totally out of control, like I’ll explode or do something I’ll regret later.”
Timing/ Treatment	“When did these feelings or episodes start? How long do they usually last?”	“I’ve felt like this ever since I was a teenager. The episodes can come on fast, like after a text from my boyfriend, and can last for hours or days.”
Understanding	“How do you explain what you’re going through?”	“I’m very sensitive. I know I can be intense or push people away, but I can’t help it. If people leave me, I don’t know how to handle it. It’s like I feel everything too much.”

SUICIDE AND SELF INJURY SCREENING

Clients being evaluated or treated for personality disorders may have suicidal ideation. It is important for the nurse to introduce suicide screening in a way that helps the client understand its purpose and normalize questions that might otherwise seem intrusive. The Patient Safety Screener (PSS-3) is an example of a brief screening tool to detect suicide risk in all client presenting to acute care settings.⁴

Non-suicidal self-injury (NSSI) refers to intentional self-inflicted destruction of body tissue without suicidal intention and for purposes not socially sanctioned. Common forms of NSSI include behaviors such as cutting, burning, scratching, and self-hitting. It is considered a maladaptive coping strategy without the desire to die. NSSI is a common finding among adolescents and young adults in psychiatric inpatient settings.⁵

Review information about suicide screening, the Patient Safety Screener, and screening for non-suicidal self-injury (NSSI) in the “[Assessment](#)” section of the *Applying the Nursing Process to Mental Health Care* chapter.

CULTURAL ASSESSMENT

Cultural Formulation Interview (CFI) questions help nurses understand a client’s cultural background and how it influences their experience of mental health symptoms, including personality disorders.⁶ Sample CFI questions

4. Suicide Prevention Resource Center. (n.d.). *The patient safety screener: A brief tool to detect suicide risk*. <https://sprc.org/micro-learning/patientsafetyscreener>
5. Cipriano, A., Cella, S., & Cotrufo, P. (2017). Nonsuicidal self-injury: A systematic review. *Frontiers in Psychology*, 8. <https://www.frontiersin.org/articles/10.3389/fpsyg.2017.01946/full>
6. DeSilva, R., Aggarwall, N. K., & Lewis-Fernandez, R. (2015). The DSM-5 cultural formulation interview and the evolution of cultural assessment in psychiatry.

focused specifically on understanding depression within a cultural context include the following:

- Cultural Definition of the Problem
 - “How would you describe the problems you’re having with relationships or emotions?”
 - “What do your family or friend call these difficulties?”
 - “Do others see your behavior or emotions as a problem? If so, how?”
- Cultural Perceptions of Cause, Context, and Support
 - “What do you think causes your emotional ups and downs or relationship conflicts?”
 - “How does your family or cultural group view traits like being very emotional, needing control, being distrustful, or acting out?”
 - “Are there things happening in your life right now that are making these problems worse?”
- Cultural Factors Affecting Coping and Help-Seeking
 - “What have you done to manage these emotions on your own?”
 - “Have you talked to family members, elders, or religious/spiritual leaders about these issues?”
 - “What kind of help do you think would work best for you?”
 - “Are there treatments or approaches you’re uncomfortable with, based on your beliefs or past experiences?”
- Cultural Features of the Nurse–Client Relationship
 - “Are there things about your cultural background that would help me understand you better or make you feel more comfortable?”
 - “Have you had any past experiences with mental health or medical providers that affect how you feel about treatment now?”
 - “Would you prefer working with a provider of a certain background or

Psychiatric Times, 32(6). <https://www.psychiatrictimes.com/view/dsm-5-cultural-formulation-interview-and-evolution-cultural-assessment-psychiatry>

gender?”

Findings from the cultural formulation interview are used to individualize a client’s plan of care to their preferences, values, beliefs, and goals.

SPIRITUAL ASSESSMENT

The FICA Spiritual History Tool is a widely used assessment model for evaluating a client’s spiritual beliefs and how they may influence health, illness, and coping. FICA© is a mnemonic for the domains of Faith, Importance, Community, and Address in Care.⁷ The data obtained from a FICA assessment can be helpful in understanding how clients with personality disorders draw on spirituality or religion for support. Spiritual distress is very common for clients experiencing serious illness, and nurses assist clients to adopt healthy coping strategies to deal with these life events. Addressing a client’s spirituality and advocating spiritual care have been shown to improve clients’ health and quality of life.^{8,9}

7. GW School of Medicine & Health Sciences. (n.d.). *Clinical FICA tool*.
<https://smhs.gwu.edu/spirituality-health/program/transforming-practice-health-settings/clinical-fica-tool>
8. Pilger, C., Molzahn, A. E., de Oliveira, M. P., & Kusumota, L. (2016). The relationship of the spiritual and religious dimensions with quality of life and health of patients with chronic kidney disease: An integrative literature review. *Nephrology Nursing Journal: Journal of the American Nephrology Nurses’ Association*, 43(5), 411–426. <https://pubmed.ncbi.nlm.nih.gov/30550069/>
9. Puchalski, C., Jafari, N., Buller, H., Haythorn, T., Jacobs, C., & Ferrell, B. (2020). Interprofessional spiritual care education curriculum: A milestone toward the provision of spiritual care. *Journal of Palliative Medicine*, 23(6), 777–784.
<https://doi.org/10.1089/jpm.2019.0375>

Table 10.4c summarizes a sample spiritual assessment questions and sample responses from a client experiencing depression.

Table 10.4c Sample FICA Spiritual Assessment Questions for Clients with Personality Disorders

Domain	Sample Assessment Question	Sample Client Response
Faith	“Do you consider yourself spiritual or religious? What gives your life meaning?”	“Lately, I’ve been feeling disconnected from everyone and everything. I pray sometimes, but it feels like no one’s listening.”
Importance	“How important is faith or religious belief in your life?”	“My faith used to help me feel strong, especially during hard times. Now, I feel like I’ve lost that connection. I feel too broken to be helped.”
Community	“Are you part of a spiritual or religious community? Does participation in this community provide support when you’re feeling sad or in a low mood?”	“I haven’t gone to church in months. Some people from church have reached out, but I just feel like being alone when I am home after work.”
Address in Care	“Would you like me (or the health care team) to address spiritual issues during your care? Would you like to speak with a chaplain?”	“Maybe. I don’t want to feel judged for how I feel or for having doubts.”

Feelings of abandonment and spiritual distress are common in individuals experiencing personality disorders and may compound their symptoms. Nurses may recognize cues of spiritual distress and offer to connect the client with a chaplain or spiritual care services. Spiritual goals may be included in the nursing care plan if the client finds them valuable.

FAMILY DYNAMICS

Family dynamics are included in a psychosocial assessment, especially for children, adolescents, and older adults. **Family dynamics** refers to the patterns of interactions among relatives, their roles and relationships, and the various factors that shape their interactions. Because family members rely on

each other for emotional, physical, and economic support, they are primary sources of relationship security or stress. Family dynamics and the quality of family relationships can have either a positive or negative impact on an individual's health. For example, secure and supportive family relationships can provide love, advice, and care, whereas stressful family relationships can be burdened with arguments, unhealthy relationships, and a lack of support.¹⁰

Unhealthy family dynamics can cause children to experience trauma and stress as they grow up. This type of exposure, known as adverse childhood experiences (ACEs), is linked to an increased risk of developing mental health disorders.¹¹ Review information about adverse childhood experiences (ACEs) in the “[Mental Health and Mental Illness](#)” section of Chapter 1.

Laboratory Testing

There is no specific laboratory test that diagnoses personality disorders. Laboratory or diagnostic tests may be used to rule out other possible causes for the behaviors the client is exhibiting. For example, a thyroid stimulating hormone (TSH) test may be ordered because thyroid disorders can affect mood.

Life Span Considerations

CHILDREN AND ADOLESCENTS

Formal diagnosis of a personality disorder is not made before age 18, but traits may be present earlier, such as emerging patterns of emotional instability,

10. Jabbari, B., Schoo, C., & Rouster, A. S. (2023). *Family dynamics*. StatPearls [Internet]. <https://www.ncbi.nlm.nih.gov/books/NBK560487/>

11. Jabbari, B., Schoo, C., & Rouster, A. S. (2023). *Family dynamics*. StatPearls [Internet]. <https://www.ncbi.nlm.nih.gov/books/NBK560487/>

conduct issues, or rigid thinking. Children and adolescents may demonstrate increased conflict with authority figures or manipulative behavior, impulsivity, or self-harm.

OLDER ADULTS

Personality changes in late life may suggest neurocognitive disorder, stroke, or side effects from medications. Personality traits such as paranoia, rigidity, dependency, or social isolation may become more prominent as the individual experiences loss or isolation.

Diagnosis (Analyze Cues)

Mental health disorders are diagnosed by mental health providers using the diagnostic criteria in the *DSM-5-TR*. Personality disorder diagnoses are typically not made until late adolescence or over the age of 18 because it is important to determine if the symptoms are traits of a developmental stage or pervasive traits of a personality disorder in multiple contexts. Nurses customize nursing diagnoses based on their type of personality disorder, their current signs and symptoms, and the effects on their and their family's functioning.

Nurses create individualized nursing care plans based on the client's response to their mental health disorder(s). Common nursing diagnoses related to the clusters of personality disorders include the following:

- **Cluster A:** *Social Isolation, Disturbed Thought Process, Risk for Loneliness*
- **Cluster B:** *Risk for Suicide, Risk for Self-Directed Violence, Social Isolation, Chronic Low Self-Esteem, Ineffective Coping*
- **Cluster C:** *Anxiety, Risk for Loneliness, Social Isolation*

Common nursing diagnoses for clients diagnosed and hospitalized with personality disorders are further described in Table 10.4d.

Table 10.4d Common Nursing Diagnoses for Clients With Personality Disorders^{12,13}

12. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.
13. Ackley, B., Ladwig, G., Makic, M. B., Martinez-Kratz, M., & Zanotti, M. (2020). *Nursing diagnosis handbook: An evidence-based guide to planning care* (12th ed.). Elsevier.

Nursing Diagnosis	Definition	Selected Defining Characteristics and/or Risk Factors
Risk for Suicide	Susceptible to self-inflicted, life-threatening injury.	• Reports desire to die • Statements regarding killing self • Hopelessness • Social isolation
Risk for Self-Mutilation	Deliberate self-injurious behavior causing tissue damage with the intent of causing nonfatal injury to attain relief of tension.	• Cuts or scratches on body • Ingestion or inhalation of harmful substances • Self-inflicted burns
Risk for Other-Directed Violence	Susceptible to behaviors in which an individual demonstrates they can be physically, emotionally, and/or sexually harmful to others.	• History of childhood abuse • History of cruelty to animals • History of witnessing family violence • History of fire-setting

Ineffective Coping	A pattern of invalid appraisal of stressors, with cognitive and/or behavioral efforts, that fails to manage demands related to well-being.	• Destructive behavior toward self or others • Ineffective coping strategies • Ineffective problem-solving skills
Defensive Coping	Repeated projection of falsely positive self-evaluation based on a self-protective pattern that defends against underlying perceived threats to positive self-regard.	• Difficulty maintaining relationships • Hypersensitivity to criticism • Projection of blame • Projection of responsibility
Social Isolation	Aloneness experienced by the individual and perceived as imposed by others and as a negative or threatening state.	• Hostility • Values incongruent with cultural norms • History of rejection

Ineffective Family Health Management r/t manipulative behavior	Aloneness experienced by the individual and perceived as imposed by others and as a negative or threatening state.	• Impaired communication patterns • Disturbed thought processes • Delusional thinking
Risk for Spiritual Distress as manifested by poor relationships	A state of suffering related to the impaired ability to experience meaning in life through connections with self, others, the world, or a superior being.	• Ineffective coping strategies • Perceived insufficient meaning in life • Hopelessness • Social alienation

Outcome Identification (Generate Solutions)

Outcomes should address the established nursing diagnoses for each client with prioritization on safety. For example, if the client has a nursing diagnosis of *Risk for Self-Mutilation*, a SMART outcome could be, “The client will refrain from intentional self-inflicted injury.” Read more information about setting SMART outcomes in the “[Application of the Nursing Process in Mental Health Care](#)” chapter.

Examples of other SMART outcomes for clients with personality disorders may include the following¹⁴:

14. Ackley, B., Ladwig, G., Makic, M. B., Martinez-Kratz, M., & Zanotti, M. (2020).

- The client will remain safe and free of injury.
- The client will seek help when experiencing urges to self-mutilate.
- The client will identify three triggers to self-mutilation after the teaching session.
- The client will describe two preferred healthy coping strategies after the teaching session.

Planning (Generate Solutions)

Evidence-based interventions are critical and should focus on managing the client's behaviors. Interventions may include establishing clear boundaries, using specific communication styles, and providing reassurance.

Pharmacotherapy may be used to manage specific symptoms, although no medications are specifically approved for personality disorders.

Promoting Safety

Individuals diagnosed with personality disorder may be suicidal, self-mutilating, impulsive, angry, manipulative, or aggressive. Nurses plan interventions according to the symptoms the client is currently exhibiting with the goal of keeping the client, others, and themselves safe and free of injury. Any threats should be taken seriously. Review interventions for clients diagnosed with *Risk of Suicide* in the "[Application of the Nursing Process in Mental Health Care](#)" chapter.

Clear boundaries and limits should be set and consistently reinforced by the health care team. When behavioral problems emerge, the nurse should calmly review therapeutic goals, limits, and boundaries with the client.¹⁵

Nursing diagnosis handbook: An evidence-based guide to planning care (12th ed.). Elsevier.

15. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

A crisis/safety plan must be developed with the client that includes the following components:

- Identifying thoughts or behaviors that increase the risk of harming self or others
- Identifying people, events, or situations that trigger those thoughts or behaviors
- Implementing coping strategies
- Reaching out to other coping resources

For example, if a client performs superficial self-injurious behavior, the nurse should act based on agency policy while remaining neutral and dressing the client's self-inflicted wounds in a matter-of-fact manner. The client may be asked to write down the sequence of events leading up to the injuries, as well as the consequences, before staff will discuss the event. This cognitive exercise encourages the client to think independently about their triggers and behaviors and facilitates discussion about alternative actions.¹⁶

Review information regarding developing a safety plan in the “[Establishing Safety](#)” section of the “Foundational Mental Health Concepts” chapter.

Implementation (Take Action)

As previously discussed in this chapter, there are ten different personality disorders that are categorized into three clusters (A, B, and C) in the DSM-5. Personality disorders within each cluster have similar patterns of behavior. Cluster A personality disorders include paranoid personality disorder, schizoid personality disorder, and schizotypal personality disorder. Cluster A is characterized as the odd, eccentric cluster. Individuals with these types of disorders often experience social awkwardness. Cluster B personality disorders include antisocial, borderline, histrionic, and narcissistic personality

16. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

disorders. Cluster B personality disorders are characterized by dramatic, overly emotional, or unpredictable thinking or behavior. Cluster C personality disorders include avoidant, dependent, and obsessive-compulsive personality disorders. Cluster C personality disorders are characterized by anxious, fearful thinking or behavior.

These disorders are often ego-syntonic, meaning that the behaviors and thoughts are consistent with the individual's self-perception and are not seen as problematic by the individual, despite causing significant issues in their life. This characteristic of personality disorders can make it challenging to implement nursing interventions when the client does not believe a problem exists.

Nursing Interventions for Personality Disorders Based on Categories of the APNA Implementation Standard

Nursing interventions for clients with personality disorders can be categorized based on the American Psychiatric Nurses Association (APNA) standard for *Implementation* that includes the *Coordination of Care; Health Teaching and Health Promotion; Pharmacological, Biological, and Integrative Therapies; Milieu Therapy; and Therapeutic Relationship and Counseling*. Read more about these subcategories in the “[Application of the Nursing Process in Mental Health Care](#)” chapter. See examples of interventions for each of these categories for clients with depressive disorders in Table 10.4e.

Table 10.4e Examples of Nursing Interventions For Personality Disorders Based on Subcategories of APNA Implementation Standard

Subcategory of the APNA Standard of Implementation	The nurse will ...	Rationale
Coordination of Care	– Collaborate with mental health professionals (e.g., therapists, psychiatrists) to ensure continuity of care. – Communicate changes in behavior or mood with the health care provider. – Facilitate referrals to community support resources such as support groups. – Assist with care transitions (e.g., hospital discharge to long-term care or other community-based facilities).	Personality disorders often require long-term, structured treatment involving multiple providers. Coordinated care ensures consistency and promotes better outcomes.
Health Teaching and Health Promotion	-Educate clients on emotional regulation, interpersonal effectiveness, and stress management strategies (e.g., using DBT skills). – Teach clients about triggers, patterns of behavior, and consequences. – Promote self-care routines and adaptive coping techniques.	Many clients with personality disorders struggle with emotional impulsivity and poor coping skills. Health teaching can enhance insight and self-management, thus reducing crises and potential hospitalizations.

Pharmacological, Biological, and Integrative Therapies	– Administer prescribed medications for symptoms (e.g., mood stabilizers for impulsivity, SSRIs for depression/anxiety). – Educate the client on the purposes of the medications-Monitor for side effects and adherence – Encourage integrative therapies (e.g., mindfulness, journaling) to supplement psychotherapy.	While medications do not cure personality disorders, they can manage co-occurring symptoms. Combined with therapy and self-care strategies, they improve overall stability.
Milieu Therapy	– Create a structured and predictable environment to promote safety and reduce chaos. – Model and reinforce appropriate social behaviors in group settings. – Establish clear, consistent boundaries and behavioral expectations.	Clients with personality disorders often test limits or experience emotional dysregulation. A therapeutic milieu with structure and consistency supports stability and learning.
Therapeutic Relationship and Counseling	– Build trust using empathy, consistency, and nonjudgmental communication. – Set and maintain professional boundaries to avoid manipulation or dependency. – Use therapeutic communication to explore core beliefs and relational patterns. – Encourage participation in long-term psychotherapy (e.g., DBT, CBT).	Clients often have a history of unstable or maladaptive relationships. A consistent, respectful therapeutic relationship helps model healthy interaction and provides a secure base for growth.

Nursing Interventions for Physiological Signs of Personality Disorders

Although personality disorders are primarily psychiatric in nature, they often contribute to physiological symptoms such as sleep disturbances, somatic

complaints, self-harm behaviors, disordered eating, and fatigue. See common interventions for these conditions in Table 10.4f.

Table 10.4f Nursing Interventions Targeting Physiological Signs of Personality Disorders¹⁷

17. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

Problem/Intervention	Rationale
Nutrition and Eating Behaviors • Assess for disordered eating patterns (e.g., bingeing or restrictive intake). • Collaborate with dietitian for nutritional planning. • Monitor intake/output and weight if needed. • Support body positivity and emotional awareness around food.	Disordered eating may be associated with efforts to control overwhelming emotions. Balanced nutrition helps stabilize mood and reduce health complications.
Sleep • Assess sleep patterns and contributing factors (e.g., anxiety, racing thoughts, substance use). • Encourage regular sleep routines and calming bedtime rituals. • Provide education on sleep hygiene (e.g., limiting screen time, reducing caffeine). • Consult provider for possible medications.	Many clients with personality disorders experience insomnia due to emotional dysregulation, anxiety, or impulsivity. Improving sleep enhances mood stability and reduces irritability and impulsive behavior.

Elimination (Gastrointestinal Discomfort) • Validate physical symptoms without reinforcing excessive health anxiety. • Rule out medical causes in collaboration with the healthcare team. • Educate on the mind–body connection and introduce relaxation techniques.	Clients, especially those with borderline or somatization traits, may express emotional distress through physical symptoms like gastrointestinal (GI) complaints. Acknowledging the GI complaint while promoting coping reduces unnecessary interventions and increases insight.
Fatigue/Energy Deficit • Assess energy levels and daily activity patterns. • Encourage structured routines with scheduled rest and activity. • Promote moderate physical activity to increase energy and reduce tension. • Monitor for medication side effects contributing to fatigue.	Emotional volatility and poor sleep can result in persistent fatigue. Routines help regulate biological rhythms, while physical activity improves mood and energy.

Self Care Deficits: Self-Harm or Injury • Monitor for and document signs of cutting, burning, or other non-suicidal self-injury (NSSI). • Remove or limit access to sharp objects or means of injury. • Engage client in developing a safety plan and alternative coping strategies (e.g., using ice, rubber bands). • Refer client to DBT-based interventions.	Self-injury is a maladaptive coping mechanism to relieve emotional pain or dissociation, especially in borderline personality disorder. Safety monitoring and skill-building reduce risk and promote healthier regulation.

Communication Tips for Clients with Personality Disorders

Helpful communication techniques for clients with personality disorders and their rationale are described in the following box.

Communication Tips: Personality Disorders^{18,19}

- Establish and maintain clear, consistent boundaries.
 - **Rationale:** Clients with personality disorders

¹⁸. Ward R. K. (2004). Assessment and management of personality disorders. *American family physician*, 70(8), 1505–1512.

¹⁹. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

—especially those with borderline or antisocial traits—may test or violate boundaries.

Consistent enforcement of limits fosters safety, trust, and structure.

- Use calm, neutral, and non-reactive language.
 - **Rationale:** Emotional neutrality helps prevent escalation when clients display anger, impulsivity, or mood instability. It also reduces reinforcement of attention-seeking or manipulative behaviors.
- Avoid power struggles or confrontation.
 - **Rationale:** Clients with narcissistic or paranoid traits may become defensive or combative. Use collaborative, non-authoritarian language to de-escalate and preserve the therapeutic alliance. Read more about de-escalating in the following subsection.
- Validate feelings without encouraging distorted behaviors.
 - **Rationale:** Statements like “I can see that you’re really upset” acknowledge emotional pain without reinforcing maladaptive coping (e.g., threats, splitting, self-harm).
- Be direct, honest, and transparent.
 - **Rationale:** Clear and open communication reduces misinterpretation and builds trust, especially with clients who have suspicious or

paranoid tendencies.

- Focus on the present.
 - **Rationale:** Redirect conversations from historical grievances or perceived slights to current goals or feelings. This helps reduce rumination and increases emotional regulation.
- Avoid over-involvement or “rescuing” behaviors.
 - **Rationale:** Maintain professional boundaries to promote client autonomy and reduce dependency.
- Watch for splitting behaviors among staff.
 - **Rationale:** Clients may view staff as all good or all bad, leading to division. Maintain team communication and a unified, consistent approach. Avoid taking sides or reacting emotionally.
- Encourage reflection instead of impulsive reaction.
 - **Rationale:** Help the client slow down and explore what they’re feeling before acting. For example, “Let’s pause for a moment and talk about what just happened.”
- Reinforce positive coping and interpersonal efforts.
 - **Rationale:** Recognize and praise the client’s use of healthy communication, emotional control, or insight to supports behavior change and

build self-esteem.

De-Escalating

The nurse should implement de-escalation strategies if the client exhibits signs of increasing levels of anxiety or agitation. Strategies include the following:

- Speaking in a calm voice
- Avoiding overreacting
- Implementing active listening
- Expressing support and concern
- Avoiding continuous eye contact
- Asking how you can help
- Reducing stimuli
- Moving slowly
- Remaining patient and not rushing them
- Offering options instead of trying to take control
- Avoiding touching the client without permission
- Verbalizing actions before initiating them
- Providing space so the client doesn't feel trapped
- Avoiding arguing and judgmental comments
- Setting limits early and enforcing them consistently across team members
- Addressing manipulative behaviors therapeutically

If the client continues to escalate, measures must be taken to keep the client and others safe. Review signs of crisis and crisis interventions in the “[Stress, Coping, and Crisis Intervention](#)” chapter. If interventions are not effective in de-escalating a client at risk to themselves or others, seclusion or restraints may be required. Review using seclusion and restraints in the “[Psychosis and](#)

Schizophrenia” chapter. Review ANA guidelines on using restraints in the “Client Rights” section of the “Legal and Ethical Considerations in Mental Health Care” chapter and information on safely implementing restraints in the “Workplace Violence” section of the “Trauma, Abuse, and Violence” chapter.

Coping Strategies

Teaching self-care and coping strategies is helpful for people diagnosed with personality disorders and their loved ones.²⁰ Read about stress management and coping strategies in the “Stress, Coping, and Crisis Intervention” chapter.

For clients seeking immediate relief from intense symptoms such as panic or depersonalization, nurses can teach how to stimulate the parasympathetic nervous system. Stimulation of the vagal nerve can result in an immediate, direct relief of intense emotions. This can be accomplished by doing the following²¹:

- Applying ice or ice-cold water to the face
- Performing paced-breathing techniques in which the exhalation phase is at least two to four counts longer than the inhalation phase. For example, advise the client to inhale while counting to four and then exhale while counting to eight.

20. American Psychiatric Association. (n.d.). *What are personality disorders?* <https://www.psychiatry.org/patients-families/personality-disorders/what-are-personality-disorders>

21. Nelson, K. J. (2021). Pharmacotherapy for personality disorders. *UpToDate*. <https://www.uptodate.com>

Collaborative Interventions

The nurse encourages collaboration with other disciplines and encourage psychotherapy and pharmacotherapy as directed by the healthcare provider. For more information on psychotherapy and pharmacotherapy in regard to treating personality disorders, see the [“Treatment for Personality Disorders”](#) section of this chapter.

Evaluation (Evaluate Outcomes)

Refer to the SMART outcomes established for each individual client to evaluate the effectiveness of the planned interventions. Modification of the established nursing care plan may be required based on the effectiveness of the interventions.

In general, the nurse can evaluate the effectiveness of interventions in clients with personality disorders with the following questions:

- Does client recognize symptoms are related to their mental health condition?
- Is the client successfully implementing adaptive coping strategies to manage their mental health disorder?
- Is the client following their prescribed treatment plan?
- Is the client adequately performing self-care activities?
- Is the client able to maintain satisfying interpersonal relationships?
- Is the client able to successfully function socially or other important areas of functioning?

10.5 Spotlight Application

Kay is a 27-year-old female who is admitted to the mental health unit for feelings of depression and suicidal ideations. She has a history of cutting her legs and arms since she was a teenager. She started psychiatric treatment at age 16 and has been admitted to the psychiatric hospital three times due to overdoses. She admits to a history of promiscuous behavior and occasional marijuana use. She is unmarried but reports having several relationships with male partners. However, she shares that the relationships “never worked out” because the partners didn’t pay enough attention to her or text her as frequently as she expected, which made her angry. She describes feelings she experienced in relationships where one day she felt as if her partner was the “best thing ever,” but the next day she “can’t stand him.” She admits to abusive behaviors toward her partners when she was angry, but states that afterwards she experiences anxiety fearing the loss of the relationship. She acknowledges having trouble getting along with others. She has very few close friends and refers to previous friends as “losers.” She is unemployed with a history of several jobs from which she was terminated because of problems with anger control. There is evidence of scarring and recent cuts on bilateral lower arms. She related these injuries to self-cutting, which she reports “makes me feel better.” She reports attending dialectical behavior therapy (DBT) in the past but hasn’t attended therapy for over a year. She feels therapy helped her to learn how to feel more “in control of her extreme feelings.”

Critical Thinking Questions:

1. List the symptoms Kay is experiencing that supports the diagnosis of borderline personality disorder (BPD).

Symptoms of BPD include anger, anxiety, impulsiveness, difficulty controlling emotions, self-injury, suicidal, intense/stormy relationships, and risky behaviors.

2. Identify possible risk factors contributing to BPD.

Possible risk factors include environmental factors that may contribute to BPD, including neglect, abuse, and genetics.

3. Discuss two types of psychotherapy that may be prescribed for clients diagnosed with BPD.

Cognitive behavioral therapy, dialectical behavioral therapy, interpersonal therapy, mentalization-based therapy, and psychodynamic therapy are types of psychotherapy that may be prescribed for clients.

4. List at least three nursing interventions that should be included in this client's care plan.

- *Explain policies, expectations, rules, and consequences upon admission.*
- *Search the client's belongings and remove anything that could be used to inflict harm to self or others.*
- *Implement suicide precautions based on a suicide risk screening tool.*
- *Set and document clear boundaries and limits and share them with team members.*
- *Encourage consistent implementation of limits by all team members; do not allow bargaining.*
- *Call out manipulative behavior when it occurs.*
- *If an episode of cutting occurs during hospitalization, remain neutral and dress the client's self-inflicted wounds in a matter-of-fact manner. Ask the client to write down the sequence of events leading up to the injuries before discussing the event. Encourage the client to think independently about her triggers and behaviors and facilitate discussion about alternative actions.*

Learning Activities

(Answers to “Learning Activities” can be found in the “Answer Key” at the end of the book. Answers to the interactive activities are provided as immediate feedback.)

Please respond to the following questions.

1. Compare the difference between obsessive-compulsive personality disorder and the anxiety disorder of obsessive-compulsive disorder (OCD).
2. Name that personality disorder. Read each scenario and choose a personality disorder associated with the traits included in the scenario:
 - a. Darla enters the breakroom at her job. She is dressed provocatively with excessive jewelry. She makes eye contact with everyone. She sits down and quickly interjects herself into the conversation. When one of her coworkers shares pictures of her new puppy,

she pulls out her cell phone to show pictures of herself and tells the group how she had a romantic weekend with her handsome, rich boyfriend.

- b. Bob has been summoned to his supervisor's office. Despite his adequate job performance, he thinks to himself, "I knew it! She's out to get me and I am getting fired! She and others walk by my desk several times a day just to check up on me and see what I am doing. And that new employee has been trying to strike conversations with me, but I am not falling for that. I am sure he just wants something from me."
- c. Debbie is distraught after her boyfriend called her and told her their relationship was over. She began yelling on the phone, "I love you and can't live without you." The ex-boyfriend ends the phone call. Debbie begins

calling him over and over;
however, he doesn't
answer the phone. She
then leaves a message
stating, "I hate you. I never
want to see you again."
Overcome with emotion,
she begins to cut her wrist
with a bobby pin.

- d. George is a loner and lives alone with his five cats. He has family members who live in the area, but he hasn't seen them in years, and that is okay with him. He has never been married or been in an intimate relationship. He does not have any close friends. He enjoys his job as a night security guard because there is little requirement for social interaction.
- e. Jordan is always trying to please others. She has trouble starting or completing projects because of a lack of self-confidence. She requires much reassurance and advice when making ordinary decisions. She

allows her boyfriend to tell her what to wear, what kind of job to look for, and with whom to associate. She is afraid of him leaving her, so she is very careful not to get him mad at her.

- f. Roger has been arrested several times for domestic abuse and driving while intoxicated. He shows no remorse for any of his actions or the injuries he has caused others. He lies, breaks laws, and has no regard for the feelings of others. As a teenager, he was always in trouble and truant from school. He was incarcerated in the past but found it easy to manipulate the guards into breaking the rules for him.
- g. Deanna has very few friends. She is shy and avoids social interaction, even at work. She is worried that if she did get to know people better, she might say or do something embarrassing, and they

might criticize or reject her. During her performance evaluation with her supervisor, she left the office crying because of minor constructive feedback she received. To prevent these painful experiences, she believes it is best to keep to herself.

- h. Billy tells everyone how important he is to his company. He believes there is no way the company would be successful without him. During work meetings, he monopolizes the conversation and strives to be the center of attention. He often asks others, “Don’t you think I did a great job with that?” Although he does not have any close relationships with coworkers, he does collaborate with a few of them because they are able to help him accomplish his goals.
- i. Bobbi works as an

administrative assistant. She is very organized and spends a lot of time making lists, scheduling, and reviewing details.

Although she has several friends, she often passes on the opportunity to get together because she spends most of her time devoted to work.

Sometimes, despite her efforts, she has difficulty finishing a project because she feels the need to check things “one more time.”

- j. Paul is loner and lacks close friends outside of his immediate family. Most view him as being very unusual, including his odd way of dressing. He wears ill-fitting and bizarre clothing combinations, such as winter boots with shorts. He is very superstitious and believes he is psychic. He believes prime numbers are unlucky and avoids objects (e.g., building floors and house numbers) that are

prime numbers.

3. Check your medication knowledge.
Select which medications are commonly used to treat severe symptoms of personality disorders.
 - a. What medications are used to treat hallucinations and paranoia?
 - b. What medications are used to treat depressed mood, mood lability, anger, and anxiety?
 - c. What medications are used to treat self-injurious behavior?
4. Compare normal adolescent development with trait similarities of personality disorders.



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2



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3

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2. “MH Personality Disorders Question Set 1” by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)
3. “MH Personality Disorders Crossword” by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)

Case Study

Nurse Handoff Report:

Situation: Tara Mitchell was admitted to the hospital last night for observation after being found outside the back door of a local bar where she works as a waitress, burning her arm with a cigarette. She has a history of non-suicidal self-injurious behavior since she was a teenager, including cutting, burning herself, and pulling out her hair. Eight months ago, she was admitted to the hospital after a suicide attempt in which she jumped out in front of a car after her shift at another local bar. She states that thinking about suicide helps her relax and she feels like she can “escape” from her distracted thoughts that occur throughout the day.

Background: Tara was diagnosed with borderline personality disorder following her most recent hospitalization. She has been non-compliant with therapy. Her medical records indicate that when growing up, her father was in the military and was often physically abusive, especially when using alcohol or drugs. He was diagnosed with PTSD after returning from serving in Somalia. Her mother worked two jobs when she was growing up and was not around much. She has two siblings, a brother and a sister, but neither remains in the area and she has not had contact with them for “several years.” Tara dropped out of college with one year of classes left to complete a Graphic Design degree. She has spent the past three years changing jobs frequently, mostly working as a bartender or waitress in local restaurants and bars.

Assessment: Since admission, Tara has been quiet and withdrawn in her room. She complains of the “worst pain ever” related to 8 circular burn marks that are present on her left

forearm in the shape of the number 8. She does not make eye contact when communicating, but instead looks outside the door or over the person's shoulder. Her hair is down and her makeup is smeared below her eyes. She is wearing hospital scrubs. During her admission assessment, Tara stated she burned her arm because she was "upset at the bartender because they did not make her drink order first." She said, "They hate me. I don't know why I keep coming back to that job. They are the most incompetent people in the world!"

Tara "zones out" at times during conversation, even in the middle of speaking a sentence. She states, "I don't even know who Tara is. I feel like I'm watching what she does from outside of my body."

Tara explains that she has a long history of frequently changing hobbies, jobs, fashion sense, and relationships based on her current social circle. At times, she thinks her friends, family, and partner are "the best thing that ever happened to me," buying them gifts and sending caring messages frequently. At other times, she completely turns on her relationships, saying, "I can't stand them" and lashes out at them in person, physically, and/or on social media. These actions cause her to feel remorse, and she feels immediate regret and a strong fear that they will leave her. Tara also has a history of sexual promiscuity, even with partners she didn't even know, and doing such acts so that her current partner doesn't know.

When asked about why she burned herself with the cigarette, she explains that she was angry that she had to work while her current boyfriend, Josh, went to a bachelor party for his best friend, Ben. She states, "I was sure that Josh was going to hook up with someone else at the party."

Reflective Questions:

1. What CUES do you recognize as relevant for providing client-centered care for Tara?
2. What is your hypothesis for Tara's priority nursing problem(s)?
3. What are your first steps in providing nursing care for Tara?

- ▶ Test your clinical judgment with a NCLEX Next Generation-style question: [Chapter 10, Assignment 1](#)⁴



- ▶ Test your clinical judgment with a NCLEX Next Generation-style question: [Chapter 10, Assignment 2](#)⁵



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5. "MH Personality Disorders Next Gen Question 2" by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)

- ▶ Test your clinical judgment with a NCLEX Next Generation-style case study: [Chapter 10, Case Study 1](#)⁶

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X Glossary

Body illusion: A perception that one's own body is significantly different from its actual configuration. For example, a person lying in bed may feel as if they are levitating.

Cluster A personality disorders: Include paranoid personality disorder, schizoid personality disorder, and schizotypal personality disorder; characterized by odd, eccentric, and socially awkward behavior.

Cluster B personality disorders: Antisocial, borderline, histrionic, and narcissistic personality disorders; characterized by dramatic, overly emotional, or unpredictable thinking or behavior.

Cluster C personality disorders: Avoidant, dependent, and obsessive-compulsive personality disorders; characterized by anxious, fearful thinking or behavior.

Dissociative symptoms: The experience of detachment or feeling as if one is outside one's body with loss of memory.

Ego synotic: Behaviors and thoughts are consistent with the individual's self-perception and are not seen as problematic by the individual, despite causing significant issues in their life

Entitlement: Unreasonable expectations of especially favorable treatment.

Ideas of reference: False beliefs that coincidental events relate to oneself. For example, a person shopping in a store sees two strangers laughing and believes they are laughing at them, when in reality the other two people do not even notice them.

Interpersonal therapy: Therapy which focuses on developing healthy relationships with others.

Magical thinking: The idea that one can influence the outcome of specific events by doing something that has no bearing on the circumstances. For example, a person watching a baseball game exhibits magical thinking when

believing that holding the remote control in a certain position caused their favorite player to hit a home run.

Mentalization-Based Therapy: A type of psychotherapy designed to help individuals improve their ability to understand and interpret their own and others' mental states—such as thoughts, feelings, and intentions. The goals are to improve self-awareness and understanding of one's own emotions, enhance empathy and understanding of others' perspectives. This subsequently helps individuals develop better interpersonal skills and communication.

Personality: A relatively stable pattern of thinking, feeling, and behaving that evolves over a person's lifetime and is unique to each individual. It is influenced by one's experiences, environment (surroundings and life situations), and inherited characteristics.

Personality disorder: An enduring pattern of inner experience and behavior that deviates significantly from the expectations of one's culture. Its onset can be traced back to adolescence or early adulthood and is present in a variety of contexts. This pattern of behavior is manifested in two or more of the following areas: cognition/perceptions, affect, interpersonal functioning, and impulse control.

Personality traits: Characteristics, whether considered good or bad, that make up one's personality.

Psychodynamic therapy: Therapy which promotes self-reflection and self-examination of problematic relationship patterns and unresolved conflicts.

Psychoeducation: Education which teaches the client about their medications, psychotherapies, and support groups available in the community

Splitting: A pattern of unstable and intense personal relationships characterized by alternating between extremes of idealization and devaluation.

Learning Objectives

- Identify assessment cues of thought behaviors
- Identify nursing priorities for clients with thought disorders
- Plan outcomes for clients with thought disorders
- Differentiate safety/protective interventions for clients with thought disorders
- Apply evidence-based practice when planning care and interventions for clients with thought disorders
- Analyze treatments for clients with thought disorders
- Apply the nursing process to clients with thought disorders at risk for suicide
- Compare and contrast delirium, psychosis, and schizophrenia

Have you ever cared for a client who was confused, disoriented, had a change in mental status, or was experiencing delirium? These are considered “altered thought processes.” There are several potential medical causes of delirium, such as a urinary tract infection in an elderly client, hypo or hyperglycemia, drug or alcohol intoxication. There are also mental health disorders that can cause altered thought processes, such as schizophrenia. This chapter will discuss psychosis, delirium, and schizophrenia and explain how to care for clients experiencing hallucinations, delusions, and other symptoms of altered thought processes.

11.2 Psychosis and Delirium

Psychosis

Approximately 3 percent of the people in the United States experience psychosis at some point in their lives. About 100,000 adolescents and young adults in the US experience their first episode of psychosis each year.¹

Psychosis is a broad term that refers to a symptom complex characterized by hallucinations, delusions, and disorganized thinking. It can occur in various psychiatric and medical conditions, including schizophrenia, mood disorders, and substance-induced states. Symptoms of psychosis include **delusions** and **hallucinations**, where the client is seeing, hearing, or experiencing other sensations and experiences that aren't real. See Figure 11.1.² for artwork titled *Hallucinations*. Other symptoms of psychosis include incoherent or nonsensical speech and behavior that is inappropriate for the situation. A **psychotic episode** is a specific, time-limited occurrence of psychotic symptoms. It can be a single event or part of a recurring pattern, such as in first-episode psychosis. A person experiencing a psychotic episode may also experience depression, anxiety, sleep problems, social withdrawal, lack of motivation, and overall difficulty functioning. When someone experiences this condition, it is referred to as a psychotic episode.³

1. National Institute of Mental Health. (n.d.). *What is psychosis?* U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/schizophrenia/raise/what-is-psychosis>
2. "Hallucinations_MET_DP808068.jpg" by [Odilon Redon](#) is in the [Public Domain](#)
3. National Institute of Mental Health. (n.d.). *What is psychosis?* U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/schizophrenia/raise/what-is-psychosis>



Figure 11.1 Hallucinations

Psychosis can be a symptom of various mental illnesses, such as schizophrenia, bipolar disorder, severe depression, or severe anxiety, but there are also other potential causes. Sleep deprivation, medical conditions such as hyperglycemia and hyperthyroidism, side effects of some prescription medications, and use of alcohol or other drugs can also cause psychotic symptoms.⁴ See Table 11.2a for a side by side comparison of Psychosis and Psychotic Episode

4. National Institute of Mental Health. (n.d.). *What is psychosis?* U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/schizophrenia/raise/what-is-psychosis>

Table 11.2 Comparison of Psychosis and Psychotic Episode^{5,6}

Aspect	Psychosis	Psychotic Episode
Definition	A mental condition characterized by a disconnection from reality.	A specific period during which symptoms of psychosis are actively experienced.
Nature	Ongoing or recurring condition; can be chronic or part of another disorder.	Acute, time-limited occurrence of psychotic symptoms.
Symptoms	Delusions, hallucinations, disorganized thinking, impaired insight.	Same symptoms as psychosis, but experienced intensely in a short time frame.
Duration	Can last weeks, months, or be lifelong (depending on cause).	Usually lasts hours to weeks; typically sudden onset.
Cause	May be due to mental illness (e.g., schizophrenia), substance use, trauma, or medical conditions.	Triggered by stress, drug use, sleep deprivation, or illness.
Diagnosis	Used to describe a condition that may be part of disorders like schizophrenia or bipolar disorder.	Not a diagnosis itself; rather, an event within a broader diagnosis.
Treatment Approach	Long-term management with antipsychotics, therapy, and support.	Immediate intervention with medications, hospitalization if needed.
Prognosis	Varies by cause; some recover fully, others may have recurring episodes.	May resolve completely or indicate the beginning of a chronic condition.
Common Misconception	Often confused with violence or multiple personality disorder.	Thought to be a “one-time” event, but may signal a larger issue.

5. Liberman, J. A., & Frist, M. B. (2018). Psychotic disorders. *The New England Journal of Medicine*, 379(3), 270-280 [doi: 10.1056/NEJMr1801490](https://doi.org/10.1056/NEJMr1801490)
6. Fusar-Poli, P., Salazar de Pablo, G., Rajkumar, R. P., López-Díaz, Á., Malhotra, S., Heckers, S., Lawrie, S. M., & Pillmann, F. (2022). Diagnosis, prognosis, and treatment of brief psychotic episodes: A review and research agenda. *Lancet Psychiatry*, 9(1), 72-83. [doi: 10.1016/S2215-0366\(21\)00121-8](https://doi.org/10.1016/S2215-0366(21)00121-8).

Early Signs of Psychosis

Typically, a person will show changes in their behavior before psychosis develops. Behavioral warning signs for psychosis include the following⁷:

- Drop in grades or worsening job performance
- New trouble thinking clearly or concentrating
- Suspiciousness; paranoid ideas or uneasiness with others
- Withdrawing socially; spending a lot more time alone than usual
- Unusual, bizarre new ideas
- Strange feelings or having no feelings at all
- Decline in self-care or personal hygiene
- Difficulty telling reality from fantasy
- Confused speech or trouble communicating

Symptoms of a Psychotic Episode

See the following box for signs and symptoms of a psychotic episode according to the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR)* by the American Psychiatric Association.

DSM5 Symptoms of a Brief Psychotic Episode⁸

7. National Institute of Mental Health. (n.d.). *What is psychosis?* U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/schizophrenia/raise/what-is-psychosis>

8. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing

- Delusions
- Hallucinations
- Disorganized speech (e.g., frequent derailment or incoherence)
- Grossly disorganized or catatonic behavior (i.e., a pronounced increase or decrease in the rate and amount of movement; purposeless excessive movement)

A brief psychotic episode is defined by a psychotic event lasting at least one day but less than one month, with an eventual return to previous level of functioning. It does not include a culturally sanctioned response, such as a person's response to the death of a loved one. The disturbance is not better explained by a major depressive disorder or bipolar disorder with psychotic features, another psychotic disorder, or the physiological effects of a substance or a medical condition. The mental health provider may specify if the symptoms are in response to significant stressors (i.e., significant events to anyone experiencing similar circumstances in the individual's culture) or has a peripartum onset (i.e., during pregnancy or within four weeks of delivery).⁹

Review information about delusions, hallucinations, and disorganized speech in the "[Application of the Nursing Process in Mental Health Care](#)" chapter.

Treatment of Psychosis

Treating psychosis involves a comprehensive, long-term approach tailored to the underlying cause of the condition. For example, if psychosis is caused by a

9. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

medical condition, side effects of medication, or withdrawal from a substance, it will resolve as these conditions are treated. If psychosis is a symptom of mental illness, treatment typically includes a combination of antipsychotic medicines and psychological therapies. The cornerstone of treatment is antipsychotic medication, which helps reduce or eliminate symptoms like hallucinations and delusions. These medications may be used long-term to prevent relapse, especially in chronic conditions such as schizophrenia. In addition to medication, individuals benefit from psychosocial interventions, including cognitive-behavioral therapy (CBT), which helps manage thought patterns and improve insight. Supportive services like case management, peer support, and vocational rehabilitation can also enhance recovery and quality of life. Family education is often included to promote a supportive environment. Treatment plans are individualized and often involve a multidisciplinary team including psychiatrists, nurses, social workers, and therapists. Read more about the treatment of psychosis associated with schizophrenia in the “[Schizophrenia](#)” section of this chapter.

A psychotic episode is typically treated as a medical emergency, especially if the person is at risk of harming themselves or others. The immediate goal is to stabilize the individual and reduce acute symptoms. Treatment usually begins with antipsychotic medication, often administered in a hospital or closely monitored outpatient setting. Short-term use of sedatives may be considered to manage agitation or insomnia. Once stabilized, care may transition to outpatient follow-up with a psychiatrist or mental health team. Identifying and addressing triggers such as stress, substance use, or underlying medical issues is essential to prevent future episodes. Education and early intervention following a first episode can significantly improve long-term outcomes, and clients are often referred to specialized early psychosis intervention programs when available.

Delirium

Psychosis caused by medical issues is often referred to as delirium. **Delirium** is a mental state in which the client becomes temporarily confused, disoriented,

and not able to think or remember clearly. It usually starts suddenly and can indicate the onset of a life-threatening medical condition. Delirium resolves as the underlying condition is effectively treated. There are many common causes of delirium, including the following^{10 11} :

- Dehydration and electrolyte imbalances
- Dementia
- Hospitalization, especially in intensive care
- Intoxication or withdrawal from alcohol or drugs
- Kidney or liver failure
- Medications, such as sedatives, opioids, anesthesia, antihistamines, anticholinergics, antidepressants, antipsychotics, or anticonvulsants
- Metabolic disorders, such as diabetic ketoacidosis (DKA)
- Serious infections, such as urinary tract infections, pneumonia, and influenza
- Severe pain
- Sleep deprivation

Advanced age makes individuals more vulnerable to delirium, especially when faced with illness or medical stress.¹²

The symptoms of delirium usually start suddenly, over a few hours or a few days, and they often come and go. The most common symptoms are as follows¹³ :

10. MedlinePlus (2023). *Delirium*. <https://medlineplus.gov/delirium.html>
11. American Delirium Society. (n.d.). *About delirium*. <https://americandeliriumsociety.org/>
12. Marcantonio, E. R. (2017). Delirium in hospitalized older adults. *The New England Journal of Medicine*, 377(15), 1456-1466. [doi: 10.1056/NEJMc1605501](https://doi.org/10.1056/NEJMc1605501)
13. MedlinePlus (2023). *Delirium*. <https://medlineplus.gov/delirium.html>

- Changes in alertness (usually more alert in the morning, less at night)
- Changing levels of consciousness
- Confusion
- Disorganized thinking or talking in a way that doesn't make sense
- Disrupted sleep patterns or sleepiness
- Emotional changes: anger, agitation, depression, irritability, or overexcitement
- Hallucinations and delusions
- Incontinence
- Memory problems, especially with short-term memory
- Trouble concentrating

Treatment depends on identifying and treating underlying causes. The symptoms of delirium can often be managed with the following interventions¹⁴ :

- Making sure the room is quiet and well-lit
- Having clocks and calendars within view
- Inviting family members to spend time in the room
- Ensuring hearing aids and glasses are worn
- Allowing for uninterrupted sleep when possible
- Getting clients up and out of bed when possible
- Encourage calorie intake and hydration
- Controlling pain with pain relievers (unless the pain medication is causing the psychosis)
- Administering prescribed medications to distressed clients at risk to themselves or to others to calm and settle them, such as haloperidol (However, administer medications with caution because oversedation can worsen delirium.)
- Avoiding the use of restraints

14. MedlinePlus. (2023). *Delirium*. <https://medlineplus.gov/delirium.html>

- ▶ View the [Confusion Assessment Method \(CAM\) PDF](#) commonly used to detect delirium.

- ▶ View the following YouTube video on managing delirium¹⁵:
[Managing Delirium Out of Hours.](#)

15. Association for Elderly Medicine Education. (2014, February 6). *Managing delirium out of hours* [Video]. YouTube. All rights reserved.
<https://youtu.be/1iKe-6lc5b0>

11.3 Schizophrenia

There is a spectrum of psychotic disorders, and schizophrenia is one of the disorders on the spectrum. **Schizophrenia** is a serious mental illness that affects how a person thinks, feels, and behaves. It also affects the person's ability to recognize their symptoms as problematic, referred to as a "lack of insight." Continuous signs of the disturbance must be present for at least six months in order for schizophrenia to be diagnosed, and potential medical conditions that could be causing delirium must be ruled out.^{1,2}

Schizophrenia is typically diagnosed in the late teen years to the early thirties and tends to emerge earlier in males than females. A diagnosis of schizophrenia often follows the first episode of psychosis when individuals first display symptoms of schizophrenia. Gradual changes in thinking, mood, and social functioning often begin before the first episode of psychosis, usually starting in mid-adolescence. (See "[Early Signs of Psychosis](#)" in the previous section.) Schizophrenia can occur in younger children, but it is rare for it to occur before late adolescence.³

1. National Institute of Mental Health. (2024). *Schizophrenia*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/schizophrenia>
2. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.
3. National Institute of Mental Health. (2024). *Schizophrenia*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/schizophrenia>

Symptoms of Schizophrenia

Symptoms of schizophrenia are classified by three categories, positive, negative, and cognitive:⁴

- **Positive symptoms:** Positive symptoms reflect behaviors or experiences that are added to a person's mental functioning they represent a distortion or excess of normal functions. Positive symptoms include hallucinations, delusions, thought disorders, disorganized speech, and alterations in behaviors. Read more about delusions and hallucinations in the "Thoughts and Perceptions" subsection of the "[Assessment](#)" section of the "Application of the Nursing Process in Mental Health Care" chapter. The most common types of delusions experienced by individuals with schizophrenia are paranoia, persecutory, grandiose, or religious ideas. For example, an individual with persecutory delusions may feel the nursing staff is trying to poison them when they administer medications. People with psychotic symptoms lose a shared sense of reality and experience the world in a distorted way.
- **Negative symptoms:** Negative symptoms refer to the absence or decrease of normal behaviors and emotional responses. They include a loss of motivation, disinterest or lack of enjoyment in daily activities, social withdrawal, difficulty showing emotions, and difficulty functioning normally. Individuals typically experience the following negative symptoms
 - Reduced motivation and difficulty planning, beginning, and sustaining activities (i.e., avolition)
 - Diminished feelings of pleasure in everyday life (i.e., anhedonia)
 - Flat affect (i.e., reduced expression of emotions via facial expression or

4. National Institute of Mental Health. (2024). *Schizophrenia*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/schizophrenia>

voice tone)

- Reduced speaking

- **Cognitive symptoms:** Cognitive symptoms refer to problems in attention, concentration, and memory. For some individuals, the cognitive symptoms of schizophrenia are subtle, but for others, they are more prominent and interfere with activities like following conversations, learning new things, or remembering appointments. Individuals typically experience symptoms such as these¹:
 - Difficulty processing information to make decisions
 - Problems using information immediately after learning it
 - Trouble focusing or paying attention

The Positive and Negative Syndrome Scale (PANSS) is a widely used tool for measuring the severity of symptoms in clients with schizophrenia. It consists of 30 items, each rated on a scale from 1 (absent) to 7 (extreme), with higher scores indicating more severe symptoms. The scale is divided into three subscales: positive symptoms (7 items), negative symptoms (7 items), and general psychopathology (16 items).

See the following box for signs and symptoms for the diagnosis of schizophrenia according to the *DSM-5-TR*.

Symptoms of Schizophrenia⁵

Schizophrenia is diagnosed when two (or more) of the following characteristics are present for a significant portion of time

5. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

during a one-month period (or less if successfully treated). At least one symptom is delusions, hallucinations, or disorganized speech:

- Delusions
- Hallucinations
- Disorganized speech (i.e., frequent derailment or incoherence)
- Grossly disorganized or catatonic behavior. (**Catatonia** is a state of unresponsiveness.)
- Negative symptoms (i.e., diminished emotional expression or avolition.)

Additionally, for a significant portion of time, the client's level of functioning in one or more areas, such as work, interpersonal relations, or self-care, is significantly below their prior level of functioning. Continuous signs of schizophrenia persist for at least six months (or less if it is successfully treated). Depressive or bipolar disorders with psychotic features must have been previously ruled out, and the disturbance is not attributable to the physiological effects of a substance or other medical condition. The provider may specify if this is the first episode or multiple episodes and if it is an acute episode, in partial remission, or in full remission.⁶

See Figure 11.2⁷ for an artwork depiction of the thought disorders associated with schizophrenia.

6. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

7. "[Schizophrenia.png](#)" by William A. Ursprung is in the [Public Domain](#)



Schizophrenia

Figure 11.2 Schizophrenia

Risk Factors for Schizophrenia

It is believed that several factors contribute to the risk of developing schizophrenia, including genetics, environment, and brain structure and function.⁸

Genetics

Schizophrenia tends to run in families. Genetic studies strongly suggest that many different genes increase the risk of developing schizophrenia, but that

8. National Institute of Mental Health. (2024). *Schizophrenia*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/schizophrenia>

no single gene causes the disorder by itself. It is not yet possible to use genetic information to predict who will develop schizophrenia.⁹

Environment

Scientists think that interactions between genetic risk and aspects of an individual's environment play a role in the development of schizophrenia. Environmental factors that may be involved include adverse childhood experiences (ACE) or exposure to viruses or nutritional problems before birth.¹⁰ Other environmental risk factors include urban upbringing, migration, and early life adversities.¹¹ A systematic review found that cannabis (marijuana) worsens symptoms of psychosis in genetically predisposed individuals and causes more relapses and hospitalizations.¹²

9. National Institute of Mental Health. (2024). *Schizophrenia*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/schizophrenia>
10. National Institute of Mental Health. (2024). *Schizophrenia*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/schizophrenia>
11. Tandon, R., Nasrallah, H., Akbarian, S., Carpenter, W. T., DeLisi, L. E., Gaebel, W., Green, M. F., Gur, R. E., Heckers, S., Kane, J. M., Malaspina, D., Meyer-Lindenberg, A., Murray, R., Owen, M., Smoller, J. W., Yassin, W., & Keshavan, M. (2024). The schizophrenia syndrome, circa 2024: What we know and how that informs its nature. *Schizophrenia Research*. 264, 1-28. [doi: 10.1016/j.schres.2023.11.015](https://doi.org/10.1016/j.schres.2023.11.015).
12. Patel, S., Khan, M. S., & Hamid, P. (2020). The association between cannabis use and schizophrenia: Causative or curative? A systematic review. *Cureus*, 12(7), e9309. <https://doi.org/10.7759/cureus.9309>

Brain Structure and Function

Scientists think that differences in brain structure, function, and interactions among neurotransmitters may contribute to the development of schizophrenia. For example, differences in the volumes of specific components of the brain, the manner in which regions of the brain are connected and work together, and neurotransmitters, such as dopamine, are found in people with schizophrenia. Differences in brain connections and brain circuits seen in people with schizophrenia may begin developing before birth. Changes to the brain that occur during puberty may trigger psychotic episodes in people who are already vulnerable due to genetics, environmental exposures, or the types of brain differences mentioned previously.¹³



View the following YouTube video on an individual's experience with psychosis¹⁴: [What is Psychosis?](https://youtu.be/Pgsujx2UQl8)

Treatment

Early treatment of psychosis increases the chance of a successful remission.¹⁵

13. National Institute of Mental Health. (2024). *Schizophrenia*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/schizophrenia>

14. Living Well with Schizophrenia. (2019, July 17). *What is psychosis?* [Video]. YouTube. All rights reserved. <https://youtu.be/Pgsujx2UQl8>

15. National Institute of Mental Health. (2024). *Schizophrenia*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/schizophrenia>

Treatments focus on managing symptoms and solving problems related to day-to-day functioning and include antipsychotic medications, psychosocial treatments, family education and support, coordinated specialty care, and assertive community treatment.¹⁶

Antipsychotic Medications

Antipsychotic medications reduce the intensity and frequency of psychotic symptoms by inhibiting dopamine receptors. Certain symptoms of psychosis, such as feeling agitated and having hallucinations, resolve within days of starting an antipsychotic medication. Symptoms like delusions usually resolve within a few weeks, but the full effects of the medication may not be seen for up to six weeks.¹⁷

First-generation antipsychotics(also called “typical antipsychotics”) treat positive symptoms of schizophrenia and have several potential adverse effects due to their tight binding to dopamine receptors. Medication is prescribed based on the client’s ability to tolerate the adverse effects. **Second-generation antipsychotics**(also referred to as “atypical antipsychotics”) treat both positive and negative symptoms of schizophrenia. They have fewer adverse effects because they block selective dopamine D2 receptors, as well as serotonin, so they are generally better tolerated than first-generation antipsychotics. Clients respond differently to antipsychotic medications, so it

16. National Institute of Mental Health. (2020). *Schizophrenia*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/schizophrenia>

17. National Institute of Mental Health. (2023). *Mental health medications*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/mental-health-medications#part_2362

may take several trials of different medications to find the one that works best for their symptoms.¹⁸

See Table 11.3 for a list of common antipsychotic medications. They are usually taken daily in pill or liquid form. Some antipsychotic medications can also be administered as injections twice a month, monthly, every three months, or every six months, which can be more convenient and improve medication adherence.

- ▶ Review information on neuroreceptors affected by antipsychotic medications in the “[Antipsychotics](#)” section of the “Psychotropic Medications” chapter.

Table 11.3 Common Antipsychotic Medications^{19, 20, 21}

18. National Institute of Mental Health. (2023). *Mental health medications*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/mental-health-medications#part_2362
19. National Institute of Mental Health. (2023). *Mental health medications*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/mental-health-medications#part_2362
20. Vasan, S., & Padhy, R. K. (2023). *Tardive dyskinesia*. StatPearls [Internet]. <https://www.ncbi.nlm.nih.gov/books/NBK448207/>
21. Jibson, M. D. (2021). Second-generation antipsychotic medications: Pharmacology, administration, and side effects. *UpToDate*. www.uptodate.com

Medication Class	Mechanism of Action	Adverse Effects
First-Generation (Typical) Examples: Chlorpromazine Haloperidol Perphenazine Fluphenazine	Postsynaptic blockade of dopamine receptors in the brain	• Extrapyrarnidal side effects (EPS) • Tardive dyskinesia (TD) • Neuroleptic Malignant Syndrome (NMS)
Second-Generation (Atypical) Examples: Risperidone Olanzapine Quetiapine Ziprasidone Aripiprazole Paliperidone Lurasidone Clozapine	Postsynaptic blockade of dopamine receptors in the brain	• Metabolic syndrome • Akathisia • Decreased risk for EPS, TD, and NMS

CLOZAPINE

Clients with treatment-resistant schizophrenia may be prescribed clozapine, a specific type of atypical antipsychotic medication. However, people treated with clozapine must undergo routine blood testing to detect a potentially dangerous side effect called **agranulocytosis** (extremely low white blood cell

count). Clozapine also has strong anticholinergic, sedative, cardiac, and hypotensive properties and frequent drug-drug interactions.²²

BLACK BOX WARNING

A Black Box Warning states that elderly clients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death.²³

ADVERSE EFFECTS

Common side effects of both first- and second-generation antipsychotics include the following²⁴:

- Anticholinergic symptoms: dry mouth, constipation, blurred vision, or urinary retention²⁵
- Drowsiness
- Dizziness

22. Jibson, M. D. (2021). Second-generation antipsychotic medications: Pharmacology, administration, and side effects. *UpToDate*. www.uptodate.com
23. United States. Department of Health and Human Services. Office of Inspector General. (2021). *CMS could improve the data it uses to monitor antipsychotic drugs in nursing homes*. <https://collections.nlm.nih.gov/catalog/nlm:nlmuid-9918384885506676-pdf>
24. National Institute of Mental Health. (2023). *Mental health medications*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/mental-health-medications#part_2362
25. Jibson, M. D. (2021). Second-generation antipsychotic medications: Pharmacology, administration, and side effects. *UpToDate*. www.uptodate.com

- Restlessness
- Weight gain
- Nausea or vomiting
- Low blood pressure

First-generation antipsychotics, also known as neuroleptics or typical antipsychotics, have significant potential to cause extrapyramidal side effects and tardive dyskinesia due to their tight binding to dopamine receptors. The risk for developing these movement disorders is the primary difference between first-generation antipsychotics and second-generation antipsychotics (also known as atypical antipsychotics). In other respects, the two classes of medication have similar side effects and mechanisms of action.²⁶

Extrapyramidal (EPS) side effects refer to **akathisia** (psychomotor restlessness), rigidity, **bradykinesia** (slowed movement), tremor, and **dystonia** (involuntary contractions of muscles of the extremities, face, neck, abdomen, pelvis, or larynx in either sustained or intermittent patterns that lead to abnormal movements or postures). See Figure 11.3²⁷ for an image of dystonia.

Acute dystonic reactions affecting the larynx can be a medical emergency requiring intubation and mechanical ventilation. EPS symptoms usually resolve dramatically within 10 to 30 minutes of administration of parenteral anticholinergics such as diphenhydramine and benztropine.²⁸

Tardive dyskinesia (TD) is a syndrome of movement disorders that can occur

26. Jibson, M. D. (2021). Second-generation antipsychotic medications: Pharmacology, administration, and side effects. *UpToDate*. www.uptodate.com

27. “[Dystonia2010.JPG](#)” by [James Heilman, MD](#) is licensed under [CC BY-SA 3.0](#)

28. Lewis, K., & O’Day, C. S. (2023). *Dystonic reactions*. StatPearls [Internet]. <https://www.ncbi.nlm.nih.gov/books/NBK531466/>

in clients taking first-generation antipsychotics. Hallmark symptoms are smacking and puckering lips, eye blinking, grimacing, and twitching. TD persists for at least one month and can last up to several years despite discontinuation of the medications. Primary treatment of TD includes discontinuation of first-generation antipsychotics and may include the addition of another medication. Second-generation VMAT2 inhibitors such as deutetrabenazine and valbenazine are considered first-line treatment for TD. Clonazepam and ginkgo biloba have also shown good effectiveness for improving symptoms of TD.^{29,30}

29. Vasan, S., & Padhy, R. K. (2023). Tardive dyskinesia. StatPearls [Internet]. <https://www.ncbi.nlm.nih.gov/books/NBK448207/>
30. Pontone, G. (2020). Treating Tardive Dyskinesia: A Clinical Conundrum and New Approaches. *Drug Induced Disorders: The Clinical Essentials*. Psychopharmacology Institute. <https://psychopharmacologyinstitute.com/section/treating-tardive-dyskinesia-a-clinical-conundrum-and-new-approaches-2557-4810#:~:text=Clonazepam%20probably%20improves%20tard>
[iv](#)



Figure 11.3 Dystonia



View a supplementary YouTube video on tardive dyskinesia³¹: [Understanding Tardive Dyskinesia](https://youtu.be/gBCiWt-4Cm4).

Neuroleptic malignant syndrome (NMS) is a rare but fatal adverse effect that can occur at any time during treatment with antipsychotics. It typically develops over a period of days to weeks and resolves in approximately nine days with treatment. Signs include increased temperature, severe muscular rigidity, confusion, agitation, hyperreflexia, elevation in white blood cell count, elevated creatinine phosphokinase, elevated liver enzymes, myoglobinuria, and acute renal failure. The antipsychotic should be immediately

31. Alliance for Patient Access. (2019, October 14). *Understanding tardive dyskinesia* [Video]. YouTube. All rights reserved. <https://youtu.be/gBCiWt-4Cm4>

discontinued when signs occur. Dantrolene and bromocriptine are typically prescribed for treatment. Nursing interventions include adequate hydration, cooling, and close monitoring of vital signs and serum electrolytes.³²

 View a supplementary YouTube video³³ on NMS:
[Neuroleptic Malignant Syndrome in 3 Minutes](#)

Second-generation antipsychotics have a significantly decreased risk of extrapyramidal side effects but are associated with weight gain and the development of metabolic syndrome.³⁴ **Metabolic syndrome** is a cluster of conditions that occur together, increasing the risk of heart disease, stroke, and type 2 diabetes. Symptoms include increased blood pressure; high blood sugar; excess body fat around the waist (also referred to as having an “apple waistline”); and abnormal cholesterol, triglyceride levels, and high-density lipoprotein (HDL) levels. Weight, glucose levels, and lipid levels should be monitored before treatment is initiated then annually.

32. Chokhawala, K., & Stevens, L. (2023). Antipsychotic medications. StatPearls [Internet]. <https://www.ncbi.nlm.nih.gov/books/NBK519503/>

33. TownsendTeaching. 2022, August 28). *Neuroleptic Malignant Syndrome in 3 Minutes* [Video]. YouTube. All rights reserved.
<https://www.youtube.com/watch?v=s73S6o4wIE0>

34. Chokhawala, K., & Stevens, L. (2023). Antipsychotic medications. StatPearls [Internet]. <https://www.ncbi.nlm.nih.gov/books/NBK519503/>



View a supplementary YouTube video³⁵ on metabolic syndrome: [What is Metabolic Syndrome?](#)



View this PDF comparison: [Adverse Effects of Antipsychotic Medications.](#)

CLIENT EDUCATION

Clients should be advised to contact their provider if and side effects occur. This includes the development of any involuntary or uncontrollable movements. They should be warned to not suddenly stop taking the medication because abrupt withdrawal can cause dizziness; nausea and vomiting; and uncontrolled movements of the mouth, tongue, or jaw. Clients should be warned to not consume alcohol or other CNS depressants because their ability to operate machinery or drive may be impaired.

RELAPSE

Some people may experience relapse, meaning their psychosis symptoms come back or get worse. Relapses typically occur when people stop taking their prescribed antipsychotic medication or when they take it sporadically. Some people stop taking prescribed medications because they feel better or they feel that they don't need it anymore, but medication should never be stopped suddenly. After talking with a prescriber, clients can gradually taper

35. Health Link. (2019, December 31). What is metabolic Syndrome? [Video]. YouTube. All rights reserved. https://youtu.be/fVMvY_Lsqzw

their medications in some situations. However, most people with schizophrenia must stay on an antipsychotic continuously for months, years, or indefinitely for mental wellness.³⁶

Psychosocial Treatments

Cognitive behavioral therapy, behavioral skills training, supported employment, and cognitive remediation interventions are types of psychosocial treatments that can help address the negative and cognitive symptoms of schizophrenia. A combination of these therapies and antipsychotic medication is a common treatment approach for schizophrenia. Psychosocial treatments can help improve an individual's coping skills with the everyday challenges of schizophrenia. Therapies can also help people pursue their life goals, such as attending school, working, or forming relationships. Individuals who participate in regular psychosocial treatments are less likely to relapse or be hospitalized.³⁷

Family Education and Support

Psychosis and schizophrenia can take a heavy toll on a client's family members, significant others, and friends. Educational programs offer instruction about schizophrenia symptoms, treatments, and strategies for assisting their loved one experiencing psychosis and schizophrenia. Increasing their understanding of psychotic symptoms, treatment options, and the course of recovery can lessen their distress, bolster their own coping

36. National Institute of Mental Health. (2023). *Mental health medications*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/mental-health-medications#part_2362

37. National Institute of Mental Health. (2024). *Schizophrenia*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/schizophrenia>

strategies, and empower them to offer effective assistance to their loved one. Family-based services may be provided on an individual basis or through multi-family workshops and support groups.

- ▶ For more information about family-based services in your area, visit the family education and support groups page on the [National Alliance on Mental Illness](#) website.³⁸

Coordinated Specialty Care

Coordinated specialty care (CSC) is a general term used to describe recovery-oriented treatment programs for people with first-episode psychosis, an early stage of schizophrenia. A team of health professionals and specialists deliver CSC that includes psychotherapy, medication management, case management, employment and education support, and family education and support. The person with early psychosis and the team work together in a client-centered and family-centered approach to make treatment decisions. Compared to typical care for early psychosis, CSC is more effective at reducing symptoms, improving quality of life, and increasing involvement in work or school.³⁹

The goal is to link the individual with a CSC team as soon as possible after

38. National Institute of Mental Health. (2020, May). *Schizophrenia*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/schizophrenia>

39. National Institute of Mental Health. (2024). *Schizophrenia*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/schizophrenia>

psychotic symptoms begin. There are many different programs that are considered CSC in the United States, including (but are not limited to) Comprehensive Community Support (CCS), Community Support Programs (CSP), NAVIGATE, Connection Program, OnTrackNY, Specialized Treatment Early in Psychosis (STEP) program, and Early Assessment and Support Alliance (EASA). Supported Employment/Education (SEE) is an important part of CSC that helps individuals return to work or school because it addresses the client's personal goals. A SEE specialist helps clients develop the skills they need to achieve school and work goals. In addition, the specialist can be a bridge between clients and educators or employers.⁴⁰

Research from the RAISE project (Recovery After an Initial Schizophrenia Episode) has shown that treatments for psychosis work better when they are delivered closer to the time when psychotic symptoms first appear. The goal of the RAISE project is to help decrease the likelihood of future episodes of psychosis, reduce long-term disability, and help people to get their lives back on track so they can pursue their goals.⁴¹

► Read more about the RAISE project at [RAISE Questions and Answers](#) web page.

With early diagnosis and appropriate treatment, it is possible to recover from psychosis. Many people who receive early treatment never have another psychotic episode. For other people, recovery means the ability to live a

40. National Institute of Mental Health. (n.d.). *What is psychosis?* U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/schizophrenia/raise/what-is-psychosis>

41. National Institute of Mental Health. (n.d.). *Raise researchers.* U.S. Department of Health and Human Services.

fulfilling and productive life, even if psychotic symptoms return at times. However, if untreated, psychotic symptoms can cause disruptions in school and work, strained family relations, and separation from friends. The longer the symptoms go untreated, the greater the risk for developing additional problems. These problems can include abusing substances, having legal trouble, or becoming homeless.⁴²

Assertive Community Treatment

Assertive Community Treatment (ACT) is designed for individuals with schizophrenia who are at risk for repeated hospitalizations or homelessness. Research has demonstrated a prevalence of psychosis as high as 21% among homeless people living on the street.⁴³ See Figure 11.4⁴⁴ for an image of a homeless man. ACT is based on a multidisciplinary team approach, including a medication prescriber, a shared caseload among team members, direct service provision by team members, high frequency of client contact, low client to staff ratios, and outreach to clients in the community. ACT has been shown to reduce hospitalizations and homelessness among individuals with schizophrenia.⁴⁵

- 42. National Institute of Mental Health. (n.d.). *What is psychosis?* U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/schizophrenia/raise/what-is-psychosis>
- 43. Ayano, G., Tesfaw, G., & Shumet, S. (2019). The prevalence of schizophrenia and other psychotic disorders among homeless people: A systematic review and meta-analysis. *BMC Psychiatry*, 19(370). <https://doi.org/10.1186/s12888-019-2361-7>
- 44. “HomelessParis_7032101.jpg” by Eric Pouhier is licensed under [CC BY-SA 2.5](https://creativecommons.org/licenses/by-sa/2.5/)
- 45. National Institute of Mental Health. (2024). *Schizophrenia*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/schizophrenia>



Figure 11.4 Homelessness

- Read more information about [ACT programs](#) on the Substance Abuse and Mental Health Services Administration (SAMHSA) website.

11.4 Applying the Nursing Process to Schizophrenia

The focus of the nursing process for a client with a thought disorder should center on providing client-centered care that addresses the individual's unique needs and experiences. This includes a holistic approach that considers emotional, cognitive, and social factors, while ensuring safety and minimizing risks of self-harm or harm to others. The actions taken by the nurse will differ depending on which phase of the illness the client is in: acute, stabilization, or maintenance.

Assessment (Recognizing Cues)

Assessment includes several components, such as a mental status examination, psychosocial assessment, cultural assessment, spiritual assessment, screening with validated tools, reviewing laboratory testing results, and including lifespan considerations.

Mental Status Examination

The nursing assessment adapts to the client's phase of illness, with a focus on acute symptom management in the acute phase, treatment response and stabilization in the stabilization phase, and long-term functional and psychosocial support in the maintenance phase.

During the acute phase, the assessment focuses on identifying and managing positive psychotic symptoms such as hallucinations, delusions, and disorganized speech or behavior. Assessing the severity and impact of these symptoms on the client's functioning, as well as assessing for any immediate safety concerns, including risk of harm to self or others.

In the stabilization phase, the assessment shifts towards monitoring the reduction of acute symptoms and the emergence of any residual symptoms. This phase often involves evaluating the client's response to treatment, adherence to medication, and the presence of any side effects. The focus is also on assessing the patient's cognitive function, mood, and overall ability to engage in daily activities.

During the maintenance phase, the assessment is more comprehensive and long-term, focusing on the management of residual symptoms, particularly negative symptoms such as social withdrawal, apathy, and flat affect. the assessment should include evaluating the client’s support systems and any potential stressors that could trigger a relapse.

Common findings during a mental status examination for a client with schizophrenia who experiencing an acute psychotic episode are described in Table 11.4a. Review information about performing a mental status examination and psychosocial assessment in the “[Application of the Nursing Process in Mental Health Care](#)” chapter. It is also important to assess for suicide risk for clients with psychosis. Review how to assess for suicide risk in the “[Foundational Mental Health Concepts](#)” chapter.

Table 11.4a Common Findings During a Mental Status Examination for Individual With Schizophrenia Experiencing an Acute-Psychotic Episode¹

1. Halter, M. (2022). *Varcarolis’ foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

Assessment	Common Findings During Psychotic Episodes (*Indicates immediately notify health care provider)
Signs of Distress	*May appear internally preoccupied, anxious, fearful, or agitated. Distress may be linked to hallucinations, delusions, or paranoia. Clients may report voices commanding harm or convey fear of being watched or persecuted.
Level of Consciousness and Orientation	• Disorientation may occur during acute psychosis or in chronic cases with cognitive decline. Assess for time, place, person, and situation. • Clouded consciousness
Appearance and General Behavior	• Hygiene and grooming may be poor • Clothing may be inappropriate for the weather or mismatched. • Behavior may appear odd, withdrawn, guarded, or disorganized. • May exhibit poor eye contact or social withdrawal. • May demonstrate threatening behavior • May show negativism (a tendency to resist or oppose requests of others) • May have impaired impulse control (which can increase the risk of assault) • May exhibit boundary impairment, an impaired ability to sense where one's influence ends and another person's begins (e.g., the person might walk up to a table and drink out of someone else's glass)

Speech	• May exhibit alogia (reduction or poverty in speech), rapid or pressured speech, or halting speech • May not respond to verbal questions • May not appropriately follow instructions (based on development level) • May demonstrate looseness of associations, clang associations, neologisms, or word salad. • Speech may be tangential or circumstantial. • Neologisms words or phrases created by someone with schizophrenia.
Motor Activity	• May exhibit catatonia, a pronounced increase or decrease in the rate and amount of movement, where excessive movement is purposeless. • May demonstrate psychomotor retardation (pronounced slowness of movement) • May demonstrate psychomotor agitation (running or pacing rapidly in response to internal or external stimuli) • May exhibit echopraxia (mimicking movements of another person)
Affect and Mood	• Affect is often blunted, flat, constricted, labile, or incongruent with stated mood. • Mood may be dysphoric, anxious, or indifferent. • Clients may smile inappropriately or show no emotional response to distressing topics. • Clients may exhibit: ◦ Anhedonia (reduced ability to experience pleasure) ◦ Avolition (reduced motivation or goal-directed behavior) ◦ Asociality (decreased desire for social interaction) ◦ Apathy (decreased interest in activities that would otherwise be interesting)

Thought and Perception	• Hallucinations (false sensory perceptions not associated with real external stimuli that can include any of the five senses such as visual, auditory, tactile, gustatory, or olfactory) are a hallmark symptom of schizophrenia. • Paranoia (an irrational fear ranging from being suspicious to thinking someone is trying to kill you) is a common symptom of schizophrenia. *Suicidal or homicidal ideation can result from command hallucinations or defensive actions in response to paranoia • Often experience delusions (a fixed, false belief not held by cultural peers and persisting in the face of objective contradictory evidence) • May experience illusions(misperceptions of real stimuli) • Thought process may show disorganization, thought blocking, perseveration, or flight of ideas • May demonstrate loose associations (jumping from one idea to an unrelated idea in the same sentence), clang associations[/pb_glossary, [pb_glossary id="528"]echolalia (pathological repetition of another person's words, or magical thinking (falsely believing that reality can be changed simply by one's thoughts)
Attitude and Insight	• Attitude may be guarded, suspicious, or uncooperative. • Insight is typically impaired; clients often do not recognize their symptoms as part of an illness. They may resist treatment or deny the need for help. Anosognosia is the inability to recognize that one is ill.

Cognitive Abilities	• Memory and attention may be impaired. • Abstract thinking is often poor and concrete thinking is common. • Clients may show difficulty with problem-solving, executive functioning, and reasoning.
Examiner's Reaction to Client	• Frustration • Anxiousness • Countertransference

When assessing hallucinations, do not imply the perceptions are real. For example, a nurse should ask the client, “What do you hear?” not “What are the voices saying?” It is important to assess for command hallucinations, such as, “Are you hearing a voice that is telling you to do something,” followed by, “Do you believe what you hear is real?” If the answer is “Yes,” the client is at increased risk for acting on the command. Assess when the hallucinations began, their content, and the manner in which the client experiences them (i.e., Are they supportive or distressing? In the background or intrusive?). Ask what makes them worse or better, how the client responds, and what they do to cope with the hallucinations.²

When assessing delusions, determine if the client is capable of reality testing (i.e., questioning their thoughts and determining what is real). Ask the client if they believe there is any danger related to the delusion.³

2. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

3. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

Countertransference, which refers to the nurse's or health care professional's emotional reactions to a client, can be particularly complex when working with individuals diagnosed with schizophrenia. These reactions can be intense and multifaceted. Understanding and managing countertransference is crucial for effective interventions with this population, as it can significantly impact the nurse-client therapeutic relationship and the client's progress.

Psychosocial Assessment

As previously discussed in the “[Application of the Nursing Process in Mental Health Care](#)” chapter, a psychosocial assessment obtains additional subjective data that detects risks and identifies treatment opportunities and resources.^{4,5}

- Reason for seeking health care (i.e., “chief complaint”)
- Thoughts of self-harm or suicide (both current and historical)
- Cultural assessment
- Spiritual assessment
- Family dynamics
- Current and past medical history
- Current medications
- History of previously diagnosed mental health disorders
- Previous hospitalizations
- Educational background
- Occupational background

4. Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder. (2017). *What is cognitive behavioral therapy?* American Psychological Association. <https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral>

5. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

- History of exposure to psychological trauma, violence, and domestic abuse
- Substance use (tobacco, alcohol, recreational drugs, misused prescription drugs)
- Family history of mental illness
- Coping mechanisms
- Functional ability/Activities of daily living

After identifying the reason the client is seeking health care, additional focused questions are used to obtain detailed information used to plan care. The mnemonic PQRSTU can be used to ask questions in an organized fashion. See Table 11.4b for a sample PQRST assessment for a client with schizophrenia and sample responses.

Table 11.4b Sample PQRSTU Questions for Assessing Depression

PQRSTU	Sample Questions	Sample Client Response
Provocation/ Palliation	“What tends to trigger or make your symptoms worse? What helps you feel better or more in control?”	“The voices get louder when I’m alone or stressed. Sometimes they calm down if I wear my headphones or talk to someone.”
Quality	“Can you describe what the symptoms feel like or sound like?”	“It feels like people are talking about me behind my back. The voices sound like whispers at first, then they yell. They say I’m being watched.”
Region	“Do these feelings affect your body in any way? Do you feel it in a specific place?”	“I get tense in my chest and shoulders. Sometimes I feel like bugs are crawling under my skin and I try to scratch them off.”
Severity	“On a scale of 0 to 10, how intense or distressing are the symptoms when they are at their worst?”	“It’s a 10 when the voices are yelling. I can’t think straight or focus on anything else. It feels like I’m losing control.”
Timing/ Treatment	“When did the symptoms start? How long do they last when they come on?”	“I started hearing voices when I was in college. They come and go during the day—sometimes for hours. Nighttime is worse.”
Understanding	“What do you think is causing these symptoms? How do you make sense of these feelings?”	“I think the government implanted a chip in the vaccines I received. The voices are part of their surveillance. The doctors tell me I have schizophrenia, but I’m not sure I believe that.”

SUICIDE AND SELF INJURY SCREENING

Clients with schizophrenia may have hallucinations commanding them to commit suicide or self harm or injure others. The Patient Safety Screener

(PSS-3) is an example of a brief screening tool to detect suicide risk in all client presenting to acute care settings.⁶

Non-suicidal self-injury (NSSI) refers to intentional self-inflicted destruction of body tissue without suicidal intention and for purposes not socially sanctioned. Common forms of NSSI include behaviors such as cutting, burning, scratching, and self-hitting. It is considered a maladaptive coping strategy without the desire to die. NSSI is a common finding among adolescents and young adults in psychiatric inpatient settings.⁷

Review information about suicide screening, the Patient Safety Screener, and screening for non-suicidal self-injury (NSSI) in the "[Assessment](#)" section of the Applying the Nursing Process to Mental Health Care" chapter.

CULTURAL ASSESSMENT

Cultural Formulation Interview (CFI) questions help nurses understand a client's cultural background and how it influences their experience of mental health symptoms, including psychosis.⁸ Sample CFI questions focused specifically on understanding depression within a cultural context include the following:

6. Suicide Prevention Resource Center. (n.d.). *The patient safety screener: A brief tool to detect suicide risk*. <https://sprc.org/micro-learning/patientsafetyscreener>
7. Cipriano, A., Cella, S., & Cotrufo, P. (2017). Nonsuicidal self-injury: A systematic review. *Frontiers in Psychology*, 8. <https://www.frontiersin.org/articles/10.3389/fpsyg.2017.01946/full>
8. DeSilva, R., Aggarwall, N. K., & Lewis-Fernandez, R. (2015). The DSM-5 cultural formulation interview and the evolution of cultural assessment in psychiatry. *Psychiatric Times*, 32(6). <https://www.psychiatrictimes.com/view/dsm-5-cultural-formulation-interview-and-evolution-cultural-assessment-psychiatry>

- Cultural Definition of the Problem
 - “How would you describe the problems you are having with your thoughts or experiences?”
 - “Are there any names or terms your family or community use for these experiences?”
 - “How do other people in your culture view experiences like hearing voices or seeing things?”
- Cultural Perceptions of Cause, Context, and Support
 - “What do you think is causing you to hear voices?”
 - “Do you have any cultural or spiritual beliefs that help explain what you’re going through?”
- Cultural Factors Affecting Coping and Help-Seeking
 - “What kinds of things have you done to cope with hearing these voices?”
 - “Are there any traditional remedies, rituals, or religious practices you use to feel better?”
 - “Have you tried to talk to anyone about these experiences, like family members, friends, religious leaders, or traditional healers?”
- Cultural Features of the Nurse–Client Relationship
 - “Is there anything I should know about your background or beliefs that would help me better understand you?”
 - “Do you have any concerns or hesitations you have about seeing a mental health professional?”
 - “What kind of help do you think would work best for you?”

Findings from the cultural formulation interview are used to individualize a client’s plan of care to their preferences, values, beliefs, and goals.

SPIRITUAL ASSESSMENT

The FICA Spiritual History Tool is a widely used assessment model for evaluating a client’s spiritual beliefs and how they may influence health, illness, and coping. FICA© is a mnemonic for the domains of Faith,

Importance, Community, and Address in Care.⁹ The data obtained from a FICA assessment can be helpful in understanding how clients with schizophrenia draw on spirituality or religion for support. Addressing a client's spirituality and advocating spiritual care have been shown to improve clients' health and quality of life.^{10,11}

Table 11.4c summarizes a sample spiritual assessment questions and sample responses from a client with schizophrenia.

Table 11.4c Sample FICA Spiritual Assessment Questions for Clients with Schizophrenia

9. GW School of Medicine & Health Sciences. (n.d.). *Clinical FICA tool*.
<https://smhs.gwu.edu/spirituality-health/program/transforming-practice-health-settings/clinical-fica-tool>
10. Pilger, C., Molzahn, A. E., de Oliveira, M. P., & Kusumota, L. (2016). The relationship of the spiritual and religious dimensions with quality of life and health of patients with chronic kidney disease: An integrative literature review. *Nephrology Nursing Journal: Journal of the American Nephrology Nurses' Association*, 43(5), 411–426. <https://pubmed.ncbi.nlm.nih.gov/30550069/>
11. Puchalski, C., Jafari, N., Buller, H., Haythorn, T., Jacobs, C., & Ferrell, B. (2020). Interprofessional spiritual care education curriculum: A milestone toward the provision of spiritual care. *Journal of Palliative Medicine*, 23(6), 777–784.
<https://doi.org/10.1089/jpm.2019.0375>

Domain	Sample Assessment Question	Sample Client Response
Faith	"Do you consider yourself spiritual or religious? What gives your life meaning?"	"I believe in God. Sometimes I wonder if the voices I hear are from demons?"
Importance	"What importance does your faith or belief have in your life? Has it influenced how you cope with hearing voices?"	When I pray, it helps me feel calmer. But I also get confused when I think God is sending me messages, and it's hard to know what's real."
Community	"Are you part of a spiritual or religious community? Does participation in this community provide support when you're feeling sad or in a low mood?"	"I used to go to church, but I stopped going. I felt like people were judging me for the voices I hear, and I didn't trust them. I want to go back but I don't feel safe there yet."
Address in Care	"How would you like me (or the health care team) to address spiritual issues during your care? Would you like to speak with a chaplain?"	"I'd like someone to help me figure out if what I'm hearing is a symptoms of schizophrenia, messages from God, or voices of demons. Maybe talking to a chaplain would help me figure this out."

Clients with schizophrenia may express religious delusions or spiritual distress. They may express a desire for clarity and connection. Nurses may recognize cues of spiritual distress and offer to connect the client with a chaplain or spiritual care services. Spiritual goals may be included in the nursing care plan if the client finds them valuable.

FAMILY DYNAMICS

Family dynamics are included in a psychosocial assessment, especially for children, adolescents, and older adults. **Family dynamics** refers to the patterns of interactions among relatives, their roles and relationships, and the various factors that shape their interactions. Because family members rely on each other for emotional, physical, and economic support, they are primary sources of relationship security or stress. Family dynamics and the quality of family relationships can have either a positive or negative impact on an individual's health. For example, secure and supportive family relationships can provide love, advice, and care, whereas stressful family relationships can

be burdened with arguments, unhealthy relationships, and a lack of support.¹² When possible, assess family members and significant others' knowledge of the client's illness and their response. Are they overprotective, frustrated, or anxious? Are they familiar with family support groups, respite, and other community resources?¹³

Unhealthy family dynamics can cause children to experience trauma and stress as they grow up. This type of exposure, known as adverse childhood experiences (ACEs), is linked to an increased risk of developing physical and mental health problems.¹⁴ Review information about adverse childhood experiences (ACEs) in the "[Mental Health and Mental Illness](#)" section of Chapter 1.

ASSESSMENT OF ACTIVITIES OF DAILY LIVING

Assess the client's ability to perform activities of daily living. Are they getting adequate food, fluid, sleep, and rest? Are they completing daily hygiene tasks and dressing safely for weather conditions? Are they able to control their impulses and make safe decisions?¹⁵ Nursing interventions related to the physiological symptoms of schizophrenia are discussed in the "Implementation" section.

12. Jabbari, B., Schoo, C., & Rouster, A. S. (2023). *Family dynamics*. StatPearls [Internet]. <https://www.ncbi.nlm.nih.gov/books/NBK560487/>
13. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.
14. Jabbari, B., Schoo, C., & Rouster, A. S. (2023). *Family dynamics*. StatPearls [Internet]. <https://www.ncbi.nlm.nih.gov/books/NBK560487/>
15. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

CURRENT MEDICATIONS AND ADVERSE EFFECTS

During the assessment, nurses assess if the client is taking their medications as prescribed, their effectiveness, and if they are experiencing side effects. Are there any barriers to medications or other treatment, such as cost, stigma, or mistrust of health care providers?¹⁶

Nurses also assess for adverse effects of medications, such as involuntary movements associated with the use of antipsychotic medications (e.g., extrapyramidal side effects or tardive dyskinesia). Clients are routinely assessed for these adverse effects using scales like the Abnormal Involuntary Movement Scale.

View a YouTube video¹⁷ of a nurse performing an
 assessment using an Abnormal Involuntary Movement
Scale: [Mental Health AIMS Assessment](https://youtu.be/XuulM7G6T7A)

Laboratory Testing

The potential laboratory tests and diagnostic procedures for a client with schizophrenia vary depending on whether the client is in the acute phase, stabilization phase, or maintenance phase. During the acute phase, the focus is on identifying any immediate medical issues that could be contributing to the psychotic symptoms and ensuring the client's safety. Ensure the client has had a medical workup for other potential causes of psychosis. For

16. Halter, M. (2022). *Vancouver's foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

17. Dymond Banks. (2021, February 22). Mental Health AIMS Assessment. [Video]. YouTube. All rights reserved. <https://youtu.be/XuulM7G6T7A>

example, dehydration, infection, electrolyte imbalances, abnormal blood glucose level, substance use, or withdrawal from substances can cause psychosis. Concurrent medical disorders are common and should be treated in addition to treating schizophrenia.

In the stabilization phase, the focus shifts to monitoring the client's response to treatment and managing any side effects of medications. During the maintenance phase, the goal is to ensure long-term stability and prevent relapse. If the client is currently taking psychotropic medications, therapeutic drug levels of some types of medications are required. As always, review current information from a medication reference before administering medications.

Life Span Considerations

Life span considerations influence how the client is assessed, as well as the selection of appropriate nursing interventions. It is important to individualize all interventions to the age and developmental level of the client. Review developmental stages in the “[Application of the Nursing Process in Mental Health Care](#)” chapter.

CHILDREN AND ADOLESCENTS

Onset of schizophrenia is rare before age 13, but incidence increases in late adolescence and early adulthood. It may be preceded by years of social withdrawal, academic decline, or odd behavior. Children may experience hallucinations (especially auditory), delusions, and disorganized speech/behavior. They may exhibit poor school performance, sleep disturbances, social isolation, or irritability. There is an increased risk of substance use, self-injury, and suicide in adolescents with schizophrenia.

OLDER ADULTS

New-onset schizophrenia after age 45 is uncommon. Symptoms may be attributed to delirium, dementia, or sensory impairment (e.g., hearing loss).

Polypharmacy and comorbidities complicate diagnosis. In addition to hallucinates, older adults with schizophrenia may include persecutory ideation (e.g., believing a family member is stealing from them or poisoning their food).

Diagnosis (Analyzing Cues)

Mental health disorders like schizophrenia are diagnosed by mental health providers using the *DSM-5*. Nurses create individualized nursing care plans based on the client's responses to their mental health disorders. See Table 11.4d for a list of common nursing diagnoses and human responses related to schizophrenia.

Table 11.4d Common Nursing Diagnoses Related to Schizophrenia^{18 19}

18. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

19. Ackley, B., Ladwig, G., Makic, M. B., Martinez-Kratz, M., & Zanoliti, M. (2020). *Nursing diagnosis handbook: An evidence-based guide to planning care* (12th ed.). Elsevier.

Nursing Diagnosis	Definition	Selected Defining Characteristics
Risk for Suicide	Susceptible to self-inflicted, life-threatening injury.	• Reports desire to die • Threats of killing self • Hopelessness • Social isolation
Ineffective Coping	A pattern of invalid appraisal of stressors, with cognitive and/or behavioral efforts, that fails to manage demands related to well-being.	• Alteration in concentration • Alteration in sleep pattern • Inability to meet basic needs • Ineffective coping strategies • Insufficient goal-directed behavior • Risk-taking behavior

Self-Neglect	A constellation of culturally framed behaviors involving one or more self-care activities in which there is a failure to maintain a socially accepted standard of health and well-being.	• Insufficient personal hygiene • Insufficient environmental hygiene • Nonadherence to health activity
Impaired Communication	Decreased, delayed, or absent ability to receive, process, transmit, and/or use a system of symbols.	• Inappropriate verbalizations • Difficulty comprehending communication • Difficulty expressing thoughts verbally

Imbalanced Nutrition: Less than Body Requirements	Intake of nutrients insufficient to meet metabolic needs.	• Food intake less than recommended daily allowance • Insufficient interest in food • Body weight 20% or more below ideal weight range • Read more in the “Nutrition” chapter in <i>Open RN Nursing Fundamentals</i>
Sleep Deprivation	Prolonged periods of time without sustained natural, periodic suspension of relative consciousness that provides rest.	• Anxiety • Agitation • Transient paranoia • Intrusive thoughts • Read more in the “Sleep and Rest” chapter of <i>Open RN Nursing Fundamentals</i>

Social Isolation	Aloneness experienced by the individual and perceived as imposed by others and as a negative or threatening state.	• Impaired communication patterns • Disturbed thought processes • Delusional thinking
Hopelessness	Subjective state in which an individual sees limited or no alternatives or personal choices available and is unable to mobilize energy on own behalf.	• Long-term stress from mental illness
Spiritual Distress	A state of suffering related to the impaired ability to experience meaning in life through connections with self, others, the world, or a superior being.	• Ineffective coping strategies • Perceived insufficient meaning in life • Hopelessness • Social alienation

Readiness for Enhanced Hope	A pattern of expectations and desires for mobilizing energy on one's own behalf, which can be strengthened.	• Expresses desire to enhance connectedness with others • Expresses desires to enhance sense of meaning in life

Outcome Identification (Generate Solutions)

Outcomes should be consistent with the recovery model and emphasize hope, resilience, living a full and productive life, and recovery from illness. Expected outcomes are identified based on the client's current phase of their illness: acute, stabilization, or maintenance²⁰ :

- **Acute:** The overall goal in the acute phase of schizophrenia is client safety and stabilization. An example of an expected outcome is, "The client will consistently be able to label their hallucinations as 'not real' and a symptom of their illness by discharge."²¹
- **Stabilization:** Goals during the stabilization phase focus on understanding the illness and the prescribed treatment plan, as well as controlling and/or coping with symptoms using an optimal medication and psychosocial treatment regimen. Outcomes typically target negative and cognitive symptoms of schizophrenia during this phase because

20. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

21. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

these symptoms respond less well to initial medication treatment than do positive symptoms.²² An example of an expected outcome during the stabilization phase is, “The client will establish two goal-directed activities by the end of the shift.”

- **Maintenance:** Goals during the maintenance phase focus on maintaining and increasing symptom control and optimal functioning. Factors include treatment adherence, increasing independence, and a satisfactory quality of life.²³ An example of an expected outcome during the maintenance phase is, “The client will identify advantages for taking medications by the end of Week 2.”

Planning (Generate Solutions)

Safety

Clients with command hallucinations require close monitoring for suicide, homicide, and other violence risk. Implement interventions to reduce risk of suicide as described in the “[Application of the Nursing Process in Mental Health Care](#)” chapter.

Interpersonal conflict, paranoia, delusions, impaired judgment, limited impulse control, fear, and disagreement with unit rules increase the risk for aggressive behavior.²⁴ Nursing interventions addressing increased risk for violence to self and others are described in the following box. Read more

22. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

23. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

24. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

about recognizing signs of crisis and crisis interventions in the “[Stress, Coping, and Crisis Intervention](#)” chapter.

Nursing Interventions Addressing Risk for Violence²⁵

- Assess for suicide risk and increase supervision when risk is present. Make rounds at unpredictable intervals and adjust frequency based on risk. Read more about assessing suicide risk in the “[Foundational Mental Health Concepts](#)” chapter and interventions for risk of suicide in the “[Application of the Nursing Process in Mental Health Care](#)” chapter.
- Assess for paranoid thoughts, command hallucinations, impaired impulse control, interpersonal conflict, increasing tension and desperation, and other factors that increase the risk of violence.
- Establish trust and rapport. Engage regularly with the client. Promote communication in a safe manner regarding their concerns that contribute to risk of violence. Engender goodwill and a strong nurse-client relationship.
- Take actions to ensure the client feels safe and secure.
- Teach coping skills to reduce stressors.
- Provide constructive diversion and outlets for physical energy.
- Ensure clients are taking their medications as prescribed. Consider requesting long-acting injectable medications as indicated.

25. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

- If the client targets specific peers or staff, relocate individuals as needed.
- Search client belongings thoroughly on admission and repeat the search whenever circumstances suggest the client may have made or acquired a weapon.
- Use seclusion or restraints when other alternatives have not been successful in keeping the client or others safe. Review ANA guidelines on using restraints in the "[Client Rights](#)" section of the "Legal and Ethical Considerations in Mental Health Care" chapter.

Acute Phase of Schizophrenia

Hospitalization is indicated during the acute phase of schizophrenia if the client is considered a danger to self (e.g., refuses to eat or is too disorganized to function in the community) or to others (e.g., is behaving in a threatening manner to others).²⁶ During this phase, planning focuses on selecting interventions that focus on client safety and management of acute symptoms.

During the acute phase of schizophrenia, hospitalization provides safety, structure, and support. As discussed earlier, anosognosia may impair the client's ability to recognize their mental illness. In this case, court-ordered hospitalization may be required.²⁷ Read more about court-ordered

26. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

27. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

hospitalization in the “[Legal and Ethical Considerations in Mental Health Care](#)” chapter. Nursing interventions focus on providing safety, promoting hygiene and nutrition, improving socialization, encouraging hope and self-esteem, preventing falls, using specific therapeutic techniques, addressing physiological needs, and implementing collaborative interventions.

Stabilization and Maintenance Phases

During the stabilization and maintenance phases, planning focuses on education, support, and skills training for the client and family. It also addresses how and where these needs can be met within the community. As explained previously in this chapter, relapse prevention efforts are vital. Each relapse can increase residual dysfunction and deterioration and can contribute to despair, hopelessness, and suicide risk. Additionally, recognizing early signs of relapse (e.g., reduced sleep, social withdrawal, and worsening concentration) and implementing intensive treatment are needed to minimize the disruption of the client’s life.²⁸

Implementation (Take Action)

Acute Phase

PROMOTE HYGIENE AND NUTRITION

Promote hygiene in clients experiencing psychosis by concisely and explicitly stating expected hygiene tasks. Break tasks into smaller, more manageable tasks and assist when needed. Use visual cues to prompt hygiene tasks, such as putting clean clothes on the bed or clean towels and a toothbrush in the bathroom. Share potential benefits of improved hygiene such as improved

28. Halter, M. (2022). *Varc Carolis’ foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

socialization with others. Reinforce progress in performing hygiene with verbal praise or concrete rewards like additional privileges on the unit.²⁹

Clients who are experiencing catatonia require assistance with nutrition, as well as other activities of daily living.

IMPROVE SOCIALIZATION

Regularly engage with the client. Initially interact briefly about low-anxiety topics like the weather and gradually increase the duration and frequency of interactions as they become more comfortable. Encourage clients to participate in unit activities without pressure, such as “We would like to see you at the morning meeting.” Reinforce the client’s control in their choices, such as, “If you become uncomfortable in the group, you can leave and try again on another day.” Provide positive reinforcement for attempts at socialization, such as, “It was nice to see you in the morning meeting today.”³⁰

ENCOURAGE HOPE AND SELF-ESTEEM

Convey unconditional acceptance, empathy, and support. For example, say, “Sometimes it can feel very discouraging when experiencing a mental health disorder. I am wondering how you are feeling?” If the client cannot identify their feelings, suggest words that may apply, such as, “Sometimes it is hard to say what you are feeling. Do you feel sad, frustrated, or anxious?” Validate the client’s feelings and assure them they are not alone. Help the client identify their positive traits or previous accomplishments. Suggest coping strategies such as journaling and attending a support group. Teach stress management

29. Halter, M. (2022). *Varcarolis’ foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

30. Halter, M. (2022). *Varcarolis’ foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

techniques and coping strategies as outlined in the “[Stress, Coping, and Crisis Intervention](#)” chapter.

PREVENT FALLS

Fall risk may be increased due to orthostatic hypotension, impaired balance, bradykinesia, or other movement disorders. Assess the client’s gait and for orthostatic hypotension. Teach the client to slowly change position from lying to sitting to standing and encourage the use of handrails or seeking assistance when feeling unsteady. Implement additional fall precautions as needed according to agency policy.

- ▶ Read more information about fall precautions in the “[Safety](#)” chapter of *Open RN Nursing Fundamentals*.

USE THERAPEUTIC TECHNIQUES FOR COGNITIVE IMPAIRMENTS, DELUSIONS, AND HALLUCINATIONS

Recall that clients with schizophrenia may have memory and attention impairments. Repetition with visual and verbal reminders is helpful to promote task completion. Additionally, short but frequent interactions may be less stimulating to the client and better tolerated.³¹ Additional techniques for helping clients who are experiencing delusions and hallucinations are described below.

Helping Clients Who Are Experiencing Delusions

Delusions feel very real to the client and can be frightening. Nurses should

31. Halter, M. (2022). *Varcarolis’ foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

acknowledge and accept the client's experience and feelings resulting from the delusion while conveying empathy. They can provide reassurance regarding their intentions to help the client feel safer.

Avoid questioning the delusion. Until the client's ability to test reality improves, trying to prove the delusion is incorrect can intensify it and cause the client to view the staff as people who cannot be trusted. Instead, focus on the fear and what would help the client feel safer. For example, if a client states, "The doctor is here. He wants to kill me," the nurse could respond, "Yes, the doctor is here and wants to see you. They talk with all of the clients about their treatment. Would you feel more comfortable if I stayed with you during your meeting with the doctor?" Focusing of events in the present keeps the client focused on reality and helps them distinguish what is real.³²

If a client is exhibiting paranoia and is highly suspicious, it is helpful to maintain consistent staff assignments. Staff should avoid laughing, whispering, or talking quietly where the client can see these actions but cannot hear what is being said. Staff should ask permission before touching the client, such as before taking their blood pressure.

- ▶ Read additional strategies for working with clients with delusions from the British Columbia Schizophrenia Society: [Steps for Working With Delusions](#).

Helping Clients Who Are Experiencing Hallucinations

Hallucinations feel very real to the person experiencing them and can be distracting during their interactions with others. Hallucinations can be

32. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

supportive or terrifying, faint or loud, or episodic or constant. For example, listen to simulations of auditory hallucinations in the following box. The nurse should focus on understanding the client's experiences and responses and convey empathy. Command hallucinations, suicidal ideation, or homicidal ideation requires safety measures as previously discussed in the "Provide Safety" subsection.

Simulations of Auditory Hallucinations

British Columbia Schizophrenia Society created music tracks simulating what auditory hallucinations can feel like to clients. Similar to auditory hallucinations experienced by people living with schizophrenia, when people listen to these songs, they hear voices that can be frightening. Listen to these simulations on YouTube with discretion because some people can find them disturbing:

▶◀ [Track 05: Mark Pelli - Everything \(Songs of schizophrenia mix\)](https://youtu.be/pN-f6AEDNxY)³³

▶◀ [Track 06: Cassandra Vasik - Sadly mistaken \(Songs of schizophrenia mix\)](https://youtu.be/HCewO3BL1qA)³⁴

When working with a client who has a history of hallucinations, watch for hallucination indicators, such as eyes tracking an

33. BC Schizophrenia. (2019, May 6). *Track 05: Mark Pelli – Everything (Songs of schizophrenia mix)* [Video]. YouTube. All rights reserved.

<https://youtu.be/pN-f6AEDNxY>

34. BC Schizophrenia. (2019, May 6). *Track 06: Cassandra Vasik – Sadly mistaken (Songs of schizophrenia mix)* [Video]. YouTube. All rights reserved.

<https://youtu.be/HCewO3BL1qA>

unheard speaker, muttering or talking to oneself, appearing distracted, suddenly stopping a conversation as if interrupted, or intently watching a vacant area of the room. Ask about the content of the hallucinations and if they are experiencing command hallucinations. Assess how the client is reacting to the hallucinations, especially if they are exhibiting anxiety, fear, or distress.³⁵

Avoid referring to the hallucinations as if they were real to promote reality testing. For example, do not ask, “What are the voices saying to you,” but instead ask, “You look as though you are hearing something. What do you hear?” Do not try to convince the client the hallucinations are not real, but instead offer your perception and convey empathy. For example, “I don’t hear angry voices that you hear, but that must be very frightening for you.” Address any underlying emotion, need, or theme indicated by the hallucination.³⁶

Focus on reality-based activities in the “here and now,” such as a conversation or simple project. Promote and guide reality testing. For example, guide the client to look around the room and see if others are frightened; if they are not, encourage them

35. Halter, M. (2022). *Varcarolis’ foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

36. Halter, M. (2022). *Varcarolis’ foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

to consider what they are experiencing are hallucinations. Teach the client to compare their perceptions to trusted others.³⁷

See the information in the following box for teaching clients how to manage their hallucinations.

Client Education: Teaching Clients How to Manage Hallucinations³⁸

- Manage stress and stimulation.
 - Avoid overly loud or stressful places or activities.
 - Avoid negative or overly critical people and seek out supportive people.
 - Use assertive communication skills so you can tell others “No” if they pressure or upset you.
 - When stressed, focus on your breathing and slow it down. Inhale slowly through your nose as you count from one to four, hold your breath, and then exhale slowly through your mouth.
 - Refer to other stress management and coping strategies in the “[Stress, Coping, and Crisis Intervention](#)” chapter.

³⁷. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

³⁸. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

- Use other sounds to compete with the hallucinations, such as talking with other people, listening to music or TV, reading aloud, singing, whistling, or humming.
- Determine what is real and unreal by looking at others. Do they seem to be hearing or seeing what you are? Ask trusted others if they are experiencing the same things you are. If the answers to these questions are “No,” then although it feels real, it is not likely real and can be ignored.
- Engage in activities that can take your mind off the hallucinations, such as walking, taking a relaxing bath or shower, or going to a place you find enjoyable where others are present, such as a coffee shop, mall, or library.
- Talk out loud (or silently to yourself if others are nearby) and tell the voices or thoughts to go away. Tell yourself the voices or thoughts are a symptom and not real. Tell yourself that no matter what you hear, you are safe and can ignore what you hear.
- Seek contact with others. Visit a trusted friend or family member. Call a help line or go to a drop-in center. Visit a public place where you feel comfortable.
- Develop a plan with your provider for how to cope with hallucinations. Additional medications may be prescribed to use as needed.

CATEGORIZING NURSING INTERVENTIONS ACCORDING TO THE APNA STANDARD OF IMPLEMENTATION

Interventions for clients experiencing psychosis previously discussed in this chapter can also be categorized by the standard of *Implementation* by the American Psychiatric Nursing Association (APNA). Read more about this standard in the [“Application of the Nursing Process in Mental Health Care”](#)

chapter. See Table 11.4e for categorization of nursing interventions by this standard.

Table 11.4e Nursing Interventions for Clients with Psychosis Based on the Categories of the APNA Implementation Standard³⁹

39. American Psychiatric Association. (2013). *Desk reference to the diagnostic criteria from DSM-5*.

Categories of Interventions Based on the APNA Standard of Implementation	What the nurse will do..	Rationale
Coordination of Care	• Maintain safety by implementing safety precautions as needed to prevent self-harm, suicide, or homicide risks. • Ensure consistency of behavioral expectations among all staff on the unit by including expectations in the nursing care plan. • Collaborate with psychiatry, social work, case managers, and family to ensure medication management, housing stability, and follow-up care. • Plan for quality of life, independence, and optimal recovery by referring to local resources and support groups in the community on discharge.	Schizophrenia often requires long-term, interdisciplinary management due to chronic symptoms and functional impairments. Coordinated care improves adherence and reduces rehospitalization. The client may exhibit high risk for impulsive behaviors that could pose a risk of harm to self/others. They may experience altered thought processes with poor insight and judgment. Consistent expectations provide a feeling of structure and safety. The nurse coordinates care delivery during inpatient care, and assists in making referrals for optimal recovery after discharge.

Health Teaching	• Educate the client and family about schizophrenia, early warning signs of relapse, medication side effects, and self-management strategies. Use simple, concrete language and repetition. • Include teaching topics on stress management, coping strategies, and management of delusions and hallucinations. • Screen for tobacco, alcohol, or drug use. Provide education on interactions between substances and antipsychotics. Offer motivational interviewing or referrals to substance use programs.	Many clients with schizophrenia have cognitive deficits or poor insight regarding their condition. Psychoeducation enhances adherence, decreases stigma, and supports early intervention. Nurses encourage resilience by promoting adaptive coping strategies. Many individuals with schizophrenia use substances to self-medicate symptoms, worsening outcomes. Integrated care supports recovery and medication efficacy.

Pharmacological, Biological, and Integrative Therapies	• Administer antipsychotics as prescribed (monitoring for EPS, metabolic syndrome). Support the use of long-acting injectables (LAIs) if adherence is an issue. • Deliver client education about antipsychotics and expected time frames for improvement. • Open all medications in front of the client. • Observe for and promptly report symptoms of potential adverse effects of first-generation antipsychotics such as tardive dyskinesia (TD) and extrapyramidal side effects (EPS). • Incorporate relaxation or mindfulness practices.	Medications are the cornerstone of symptom management. Monitoring improves safety, and integrative approaches support overall wellness and self-regulation. Improving the client's understanding of their medications and potential side effects can increase medication compliance. Opening all medications in front of the client may decrease paranoia. Clients experiencing TD or new EPS symptoms should discontinue first-generation antipsychotics and start second-generation antipsychotics per provider order. Medications to treat symptoms may be required.

Milieu Therapy	• Maintain a structured, low-stimulation environment with consistent routines. Use redirection when clients become agitated. Ensure safety through observation and early intervention when behaviors escalate. The client may require a private room. • Promote physical exercise to redirect aggressive behavior. • During acute psychosis with agitation, use prescribed medications, seclusion, or restraint to minimize physical harm. • Encourage participation in group therapy addressing social skills, personal grooming, mindfulness, and stress management. Avoid competitive activities or games if the client is agitated.	A therapeutic milieu reduces stress and promotes safety. Clients with schizophrenia often benefit from clear expectations, boundaries, and minimal environmental confusion. Reducing stimuli may prevent escalation of anxiety and agitation. Physical exercise can decrease tension and provide focus. During acute psychosis, the nurse's priority is to protect the client and others from harm. Group therapy can encourage effective coping skills and socialization. Structured activities provide security and focus. However, avoid competitive activities because they may be too stimulating and can cause escalation of anxiety and agitation.

Therapeutic Relationship and Counseling	• Build trust through consistent, nonjudgmental, and empathic communication. Avoid challenging delusions directly; instead, explore feelings and promote reality orientation gently. Support involvement in therapy (CBT, social skills training). • Use a firm and calm approach with short and concise statements. For example, “John, come with me. Eat this sandwich.” • Identify expectations in simple, concrete terms with consequences. For example, “John, do not yell at or hit Peter. If you cannot control yourself, the seclusion room will help you feel less out of control and prevent harm to yourself and others.” • Acknowledge feelings associated with delusions and hallucinations and convey empathy. Encourage and guide reality testing based on client status. • Redirect excessive energy	Trust is critical with clients who may be paranoid or withdrawn. A strong therapeutic alliance supports engagement, emotional expression, and adaptive functioning. Clear expectations help the client experience outside controls and understand reasons for medication, seclusion, or restraints if they are not able to control their behaviors. Acknowledging emotion and conveying empathy build trust and a strong nurse-client relationship. Reality testing helps clients manage their delusions and hallucinations. Clients may be impulsive and hyperverbal and interrupt, blame, ridicule, or manipulate others so setting limits and personal boundaries is vital.

	into appropriate and constructive channels. • Set limits with personal boundaries.	

NURSING INTERVENTIONS FOR PHYSIOLOGICAL SIGNS OF SCHIZOPHRENIA

While schizophrenia is a psychiatric condition, it frequently presents with or leads to physiological health concerns due to self-neglect, poor insight, medication side effects, and lifestyle disruptions. Nursing interventions target common physiological signs of schizophrenia and associated self-care deficits as described in Table 11.4f.

Table 11.4f Nursing Interventions Targeting Physiological Signs of Schizophrenia⁴⁰

40. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

Problem/Intervention	Rationale
Nutrition • Monitor weight and regularly. • Encourage healthy eating habits; provide structured meal times. • Educate about antipsychotic-induced weight gain and provide referrals to dietitians if needed. • Involve client in menu planning if possible.	Second generation antipsychotic medications increase the risk for metabolic syndrome (e.g., weight gain, hyperlipidemia, insulin resistance). Nutritional support reduces health risks and enhances well-being.
Sleep • Assess sleep hygiene and patterns. • Encourage routine sleep–wake cycles and a bedtime routine. • Limit caffeine and other stimulants. • Provide a calm, quiet sleep environment.	Clients often experience sleep disturbances due to psychosis or medication side effects. Adequate sleep supports emotional regulation and reduces relapse risk.
Elimination • Monitor for anticholinergic side effects (e.g., constipation, urinary retention). • Encourage fluid and fiber intake. • Provide toileting reminders if needed. • Consult provider for stool softeners or laxatives as indicated.	Antipsychotic medications can cause constipation and urinary retention, which may go unreported in clients with disorganized thinking. Prevention of constipation avoids additional complications such as fecal impaction.

Activity/Mobility • Encourage daily walking or light exercise. • Monitor for extrapyramidal symptoms (EPS), akathisia, or sedation. • Engage in structured physical activities or group movement therapy.	Medications may cause motor side effects, and sedentary behavior increases cardiovascular risk. Physical activity improves physical and mental health.
Self-Care Deficits • Assess ability to perform ADLs (e.g., bathing, grooming, dressing). • Offer verbal prompts, encouragement, and step-by-step support. When appropriate, give step-by-step reminders, such as “Wash the right side of your face and now your left.” • Establish a simple daily hygiene routine. • Reinforce successes positively.	Negative symptoms (e.g., avolition, anhedonia) can result in neglect of hygiene, increasing the risk of infection and social isolation. Structured support helps restore dignity and function.

COMMUNICATION TIPS FOR CLIENTS WITH SCHIZOPHRENIA

Helpful communication techniques for clients with schizophrenia are described in the following box.

Communication Tips: Schizophrenia

- Use short, simple, and clear sentences.

- **Rationale:** Clients with schizophrenia may have difficulty processing complex information due to thought disorganization or cognitive deficits. Clear, concise language enhances understanding.
- Speak calmly and slowly.
 - **Rationale:** A calm, non-threatening tone reduces anxiety and helps de-escalate agitation. It also models emotional regulation and helps maintain a therapeutic environment.
- Avoid arguing or challenging delusions.
 - **Rationale:** Confronting delusions directly can increase defensiveness and mistrust. Instead, acknowledge the client's feelings without reinforcing the delusion (e.g., "That sounds frightening for you.") Addressing the underlying fear, anxiety, or confusion allows for therapeutic rapport and emotional support, even if the content of their belief is not reality-based.
- Use reality-based statements gently and consistently.
 - **Rationale:** While avoiding direct confrontation, it is still important to reinforce reality (e.g., "I don't see anyone else in the room, but I understand it feels real to you.")
- Limit environmental stimuli during conversations.
 - **Rationale:** Clients may be easily overwhelmed

or distracted. A quiet, low-stimulation setting helps them focus and decreases internal and external confusion.

- Allow extra time for responses.
 - **Rationale:** Thought blocking, slowed cognition, or preoccupation with internal stimuli may delay verbal responses. Patience promotes a respectful, supportive interaction.
- Use the client's name and establish a consistent routine.
 - **Rationale:** Personalizing communication and maintaining predictable interactions increase trust and reduce paranoia or confusion.
- Be consistent and honest in all interactions.
 - **Rationale:** Clients may be suspicious or mistrustful. Consistency in messaging, behavior, and tone builds therapeutic rapport and emotional safety.

Stabilization Phase

During the stabilization phase of schizophrenia, care is focused on ongoing medication therapy, education, and CBT therapy.⁴¹

41. Keepers, G. A., Fochtman, L. J., Anzia, J. M., Benjamin, S., Lyness, J. M., Mojtabai, R., Servis, M., Walaszek, A., Buckley, P., Lenzenweger, M. F., Young, A. S., Degenhardt, A., & Hong, S. H. (2020). The American Psychiatric Association

- **Medication Management:** Continue to monitor the effectiveness and side effects of antipsychotic medications. Adjust dosages as needed to minimize side effects and ensure therapeutic efficacy.
- **Psychoeducation:** Educate the client and their family about the illness, treatment options, and the importance of medication adherence.
- **Therapeutic Interventions:** Introduce cognitive-behavioral therapy for psychosis (CBTp) to help the client develop coping strategies and reduce the impact of psychotic symptoms.

Maintenance Phase

Effective long-term management of individuals with schizophrenia requires a comprehensive, multidisciplinary approach that extends beyond symptom control.

- **Ongoing Monitoring:** Regularly assess the client's mental status, medication adherence, and side effects. Monitor for signs of relapse and intervene early to prevent full-blown episodes.
- **Supportive Services:** Provide supported employment services and assertive community treatment to help the client maintain social and occupational functioning.
- **Lifestyle and Wellness:** Encourage healthy lifestyle choices, including regular exercise, a balanced diet, and smoking cessation. Monitor metabolic parameters, as antipsychotic medications can increase the risk of metabolic syndrome. Ongoing monitoring of the client's functional status, social integration, and quality of life.

Evaluation (Evaluate Outcomes)

A client's progress is continually assessed using their individualized SMART

practice guideline for the treatment of patients with schizophrenia. *American Journal of Psychiatry*, 177(9), 868-872. [doi: 10.1176/appi.ajp.2020.177901](https://doi.org/10.1176/appi.ajp.2020.177901)

outcomes and current status. Full recovery can take months. By setting small goals, it is easier to identify and recognize progress that may occur in small increments.⁴²

Acute Phase

During the acute phase of schizophrenia treatment, the primary focus is on symptom severity, safety, and the client's immediate response to intervention. Clinicians assess changes in the Positive and Negative Syndrome Scale (PANSS) scores to determine whether there has been a reduction in the frequency and intensity of hallucinations, delusions, or other psychotic features. Monitoring for safety is also crucial—evaluating any shifts in the client's risk of harm to self or others, and observing improvements in their ability to follow safety protocols within the treatment setting. In addition, the client's immediate response to antipsychotic medications is closely observed. Providers track how quickly the symptoms respond to treatment and whether any side effects emerge that could impact further care decisions.⁴³

Stabilization Phase

In the stabilization phase, ongoing symptom monitoring helps ensure the client's progress continues. Updated PANSS scores are compared to both the baseline and acute-phase scores to evaluate trends. Clinicians identify any residual symptoms that persist and outline strategies for their management, such as medication adjustments or therapeutic interventions. Medication adherence becomes a central concern—providers assess whether the client is

42. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

43. Zhang, Y., Liang, W., Gui, J. (2025). Evaluation of the impact of refined nursing care on schizophrenia patients. *Medicine*, 104(3):e40848. [doi:10.1097/MD.00000000000040848](https://doi.org/10.1097/MD.00000000000040848).

consistently following the prescribed regimen and address any side effects that may compromise adherence. This phase is key in solidifying gains made during acute care and building a foundation for long-term stability.⁴⁴

Maintenance Phase

The maintenance phase focuses on sustaining symptom remission and promoting recovery. Long-term tracking of PANSS scores helps clinicians evaluate symptom stability over time and detect early signs of relapse. Intervention strategies are adjusted accordingly to prevent deterioration. Equally important is evaluating the client's quality of life using standardized tools like the Heinrichs-Carpenter Quality of Life Scale (QLS). Providers assess improvements in the client's ability to engage in meaningful social relationships and maintain occupational or educational roles. Preventing relapse remains a central goal during this phase; clinicians monitor medication adherence rates and identify any new stressors or triggers that could threaten stability. Preventive measures, such as psychoeducation, structured routines, and early intervention strategies, are implemented to support ongoing recovery and well-being.⁴⁵

44. Zhang, Y., Liang, W., Gui, J. (2025). Evaluation of the impact of refined nursing care on schizophrenia patients. *Medicine*, 104(3):e40848. [doi: 10.1097/MD.00000000000040848](https://doi.org/10.1097/MD.00000000000040848).

45. Zhang, Y., Liang, W., Gui, J. (2025). Evaluation of the impact of refined nursing care on schizophrenia patients. *Medicine*, 104(3):e40848. [doi: 10.1097/MD.00000000000040848](https://doi.org/10.1097/MD.00000000000040848).

11.5 Spotlight Application

 Elyn Saks, a professor of law, psychology, and psychiatry at USC, shares her experience of living with schizophrenia in a 15-minute TEDGlobal video¹: “[Elyn Saks: A Tale of Mental Illness– From the Inside.](https://www.ted.com/talks/elyn_saks_seeing_mental_illness)”

Reflective Questions:

1. What strikes you most about Dr. Sak’s journey with schizophrenia?
2. What are three takeaways points from Dr. Sak’s presentation?

 View the following YouTube video on “[What Living Well With Schizophrenia Means to Me](https://youtu.be/VUhw64iEIQw)”²

Reflective Questions:

1. TEDGlobal. (2012). *A Tale of Mental Illness — From the Inside*. [Video]. TED. All rights reserved. https://www.ted.com/talks/elyn_saks_seeing_mental_illness
2. Living Well with Schizophrenia. (2020, March 7). *What living well with schizophrenia means to me* [Video]. YouTube. All rights reserved. <https://youtu.be/VUhw64iEIQw>

1. How is Lauren's journey with schizophrenia different from Dr. Sak's?
2. What are three things you learned from Lauren's description of her journey with schizophrenia?

11.6 Learning Activities



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<https://wtcs.pressbooks.pub/nursingmhcc/?p=536#h5p-38>

1



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<https://wtcs.pressbooks.pub/nursingmhcc/?p=536#h5p-39>

2



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1. “MH Psychosis & Schizophrenia Glossary Cards” by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)
2. “MH Psychosis & Schizophrenia Drag and Drop” by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)

online here:

<https://wtcs.pressbooks.pub/nursingmhcc/?p=536#h5p-40>

3

Case Study

Situation: Parker Allen, a 28-year-old male, was admitted to a locked behavioral unit in the hospital today for paranoia, psychosis, and violent behavior after he became violent with his landlord. He threw a table at the landlord when she came to his apartment to address a noise complaint by another tenant. She then called the police, who brought him to the emergency room.

Background: Parker has a three-year history of schizophrenia. He has a Master's degree in Engineering, and works as a software developer. Parker was diagnosed with schizophrenia shortly after he completed graduate school when he became very isolated and paranoid of those around him. His first psychiatric hospitalization occurred about one year after his diagnosis with schizophrenia when he experienced auditory hallucinations and paranoid delusions. He has tried various medications, but reports he doesn't like the way they make him feel and they make it difficult for him to concentrate on his work. He currently

3. "MH Psychosis & Schizophrenia Question Set 1" by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)

prescribed medications include olanzapine 10 mg and venlafaxine extended release (XR) 75 mg daily, but he states he recently stopped taking his medications.

Assessment: Since arriving in the behavioral health unit, Parker has been withdrawn. He states, “the nurses can see my thoughts,” and explains that is why he has been staying in his room and covering his head with a blanket.

Sometimes Parker answers questions, but does so inappropriately. He tells the nurse, “I’m pretty sure you are all here to kill me, and you’re starting with the hospital food. I know how this is going to go down.” The nursing staff can only speak with Parker in short bits because he either refuses to talk or is distracted easily. He has a disheveled, dirty appearance and has refused to shower since arriving on the unit. His hair is disheveled and his beard is in need of a trim.

The nursing assistant reports that he refused to eat his dinner when he arrived on the unit, but did drink a few sips of water from a sealed water bottle. His vital signs are: Temperature, 37.0°C; Heart rate, 76 beats/min; Respiratory rate, 18 breaths/min; Blood pressure, 128/79 mmHg; and SpO₂, 95%.

When the nurse enters Parker’s room, Parker is sitting on his bed, wrapped in a blanket with most of it covering his face, facing away from the nurse and looking towards the window. As he is greeted, Parker makes no movements and does not turn to the nurse’s voice. He is mumbling quietly to himself. The nurse walks around to face Parker, and greets him again. He responds quietly, but does not make eye contact and answers with apprehension.

He appears very guarded and suspicious, keeping his arms wrapped around himself with the blanket. Beneath the blanket,

the nurse can see that he is dressed in layers of clothing and has body odor.

The nurse asks Parker if he has having suicidal thoughts. For most questions the nurse asks, Parker repeats the question back to the nurse. He rarely answers the nurse's questions and appears distracted. Parker becomes agitated when asked about hallucinations and states that he is hearing voices that tell him that the food he has been given is poisoned. He reports the voices have been constant since his arrival in the hospital, but at home he could get the voices to go away by listening to music in his headphones.

The nurse notices that Parker makes bizarre statements like, "The bammerhoff got me," and speaks in tangential language. The nurse recalls from previous documentation in the electronic medical record that Parker's landlord told the police that several other neighboring tenants in the apartment building had complained that there was loud, strange-sounding music and noises coming from his apartment into late hours of the night.

Parker does not tolerate the assessment for very long. After 15 minutes, he refuses to answer any more questions, stating, "You better find the cook. They are poisoning all of us." At that time, he lays down in his bed and pulls the covers over his head. The nurse informs Parker that they will return soon with a snack for him and thanks him for his time. He does not respond but continues to mumble in a low speech under the covers in his bed.

Reflective Questions:

1. What CUES do you recognize as important for planning Parker's care?
2. What is your hypothesis for Parker based on this information?

3. Write a SMART goal for Parker based on his priority nursing problem at this time.
4. What are your priority nursing interventions for Parker?
5. How will you evaluate if your interventions have been effective?
6. What symptoms require continued monitoring?

- ▶ Test your clinical judgment with a NCLEX Next Generation-style question: [Chapter 11, Assignment 1](#)⁴



- ▶ Test your clinical judgment with a NCLEX Next Generation-style case study: [Chapter 11, Case Study 1](#)⁵



4. "MH Psychosis & Schizophrenia Next Gen Question 1" by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)

5. "MH Psychosis & Schizophrenia Next Gen Case Study" by Kellea Ewen is licensed under [CC BY-NC 4.0](#)

XI Glossary

Agranulocytosis: Extremely low white blood cell count.

Akathisia: Psychomotor restlessness (a feeling of being unable to sit still).

Alogia: Reduction or poverty in speech.

Anhedonia: The reduced ability to experience pleasure in daily activities.

Anosognosia: The inability to recognize that one is ill.

Apathy: A decreased interest in activities that would otherwise be interesting.

Asociality: A decreased desire for social interaction.

Avolition: Reduced motivation or goal-directed behavior.

Boundary impairment: An impaired ability to sense where one's influence ends and another person's begins. For example, the person might walk up to a table and drink out of someone else's glass.

Bradykinesia: Slowed movement.

Catatonia: A pronounced increase or decrease in the rate and amount of movement; excessive movement is purposeless.

Clang associations: Stringing words together that rhyme without logical association and do not convey rational meaning. For example, a client exhibiting clang associations may state, "Here she comes with a cat catch a rat match."

Cognitive symptoms: A category of symptoms of schizophrenia that refer to problems in attention, concentration, and memory, such as difficulty processing information to make decisions; problems using information immediately after learning it; and trouble focusing or paying attention.

Command hallucinations: Auditory hallucinations that command the individual to do something.

Coordinated specialty care (CSC): A general term used to describe recovery-oriented treatment programs for people with first-episode psychosis, an early stage of schizophrenia.

Delusion: A fixed, false belief not held by cultural peers and persisting in the face of objective contradictory evidence. For example, a client may have the delusion that the CIA is listening to their conversations via satellites.

Dystonia: Involuntary contractions of muscles of the extremities, face, neck, abdomen, pelvis, or larynx in either sustained or intermittent patterns that lead to abnormal movements or postures.

Echolalia: Pathological repetition of another person's words.

Echopraxia: Mimicking the movements of another person.

Extrapyramidal side effects (EPS): Adverse effects, such as akathisia, rigidity, bradykinesia, tremor, and acute-dystonic reactions, that can occur from first-generation antipsychotics,

First-generation antipsychotics: Also referred to as “typical antipsychotics”; this class of medications has several potential adverse effects due to the blockage of dopamine receptors. Medication is prescribed based on the client's ability to tolerate the adverse effects.

Flat affect: A reduced expression of emotions via facial expression or voice tone.

Hallucinations: False sensory perceptions not associated with real external stimuli that can include any of the five senses (auditory, visual, gustatory, olfactory and tactile). For example, a client may see spiders climbing on the wall or hear voices telling them to do things. These are referred to as “visual hallucinations” or “auditory hallucinations.”

Illusions: Misperceptions of real stimuli. For example, a client may misperceive tree branches blowing in the wind at night to be the arms of monsters trying to grab them.

Loose associations: Jumping from one idea to an unrelated idea in the same sentence. For example, the client might state, “I like to dance; my feet are wet.”

Magical thinking: Falsely believing that reality can be changed simply by one’s thoughts.

Metabolic syndrome: A cluster of conditions that occur together, increasing the risk of heart disease, stroke, and type 2 diabetes. Symptoms include increased blood pressure, high blood sugar, excess body fat around the waist, and abnormal cholesterol or triglyceride levels. Weight, glucose levels, and lipid levels should be monitored regularly.

Negative symptoms: A category of symptoms of schizophrenia that includes loss of motivation, diminished feelings of pleasure in everyday life, flat affect, and reduced speaking.

Neologisms: Words or phrases created by someone with schizophrenia.

Neuroleptic malignant syndrome: A rare but potentially fatal adverse effect that can occur at any time during treatment with antipsychotics. Signs include increased temperature, severe muscular rigidity, confusion, agitation, hyperreflexia, elevation in white blood cell count, elevated creatinine phosphokinase, elevated liver enzymes, myoglobinuria, and acute renal failure. The antipsychotic should be immediately discontinued if these signs occur.

Paranoia: An irrational fear that can range from being suspicious to thinking someone is trying to kill you.

Positive symptoms: A category of symptoms of schizophrenia that include hallucinations, delusions, thought disorders, disorganized speech, and alterations in behaviors.

Psychosis: Conditions where there is loss of contact with reality. Psychosis may be a symptom of a mental illness or other medical conditions. When a person experiences psychosis, their thoughts and perceptions are disturbed,

and the individual has difficulty understanding what is real and what is not real. Symptoms of psychosis include delusions and hallucinations. Other symptoms include incoherent or nonsensical speech and behavior that is inappropriate for the situation.

Psychotic episode: An episode of psychosis that can include delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behavior.¹

Schizophrenia: A severe mental illness characterized by periods of psychosis for at least six months.

Second-generation antipsychotics: Also referred to as “atypical antipsychotics”; this class of medication has fewer adverse effects because they block selective dopamine D2 receptors as well as serotonin. For this reason, they are generally better tolerated than first-generation antipsychotics.

Tardive dyskinesia (TD): A syndrome of movement disorders that can occur in clients taking first-generation antipsychotics, persisting for at least one month and up to several years despite discontinuation of the medications. The movement disorders include akathisia, dystonia, tics, and other abnormal involuntary movements.

1. American Psychiatric Association. (2013). *Desk reference to the diagnostic criteria from DSM-5*.

Learning Objectives

- Identify assessment cues of mental health disorders and neurodevelopmental disorders of childhood and adolescence
- Identify nursing priorities for clients with mental health disorders and neurodevelopmental disorders of childhood and adolescence
- Plan outcomes for clients with mental health disorders and neurodevelopmental disorders of childhood and adolescence
- Differentiate safety/protective interventions for clients with mental health disorders and neurodevelopmental disorders of childhood and adolescence
- Apply evidence-based practice when planning care and interventions for clients with mental health disorders and neurodevelopmental disorders of childhood and adolescence
- Analyze treatments for clients with mental health disorders and neurodevelopmental disorders of childhood and adolescence
- Apply the nursing process to clients with mental health disorders and neurodevelopmental disorders of childhood and adolescence at risk for suicide
- Explain conditional confidentiality and mandatory reporting related to caring for children and adolescents

Mental health disorders among children are described as “serious changes in the way children typically learn, behave, or handle their emotions, causing

distress and problems getting through the day.”¹ **Neurodevelopmental disorders** are a group of conditions with physical, learning, language, or behavioral impairments that begin during a child’s developmental period, impact their day-to-day functioning, and usually last throughout their lifetime.² Attention deficit hyperactivity disorder and autism spectrum disorder are common examples of neurodevelopmental disorders.

One in six children in the United States aged 2 to 8 years (17.4%) has a diagnosed mental health disorder, developmental disorder, or behavioral disorder. Behavior problems are more common among children aged 6 to 11 years.³

This chapter will discuss common mental health disorders and neurodevelopmental disorders in children and adolescents and collaborative treatments.

1. Centers for Disease Control and Prevention. (2022). *Data and statistics on children’s mental health*. https://www.cdc.gov/children-mental-health/data-research/?CDC_AAref_Val=https://www.cdc.gov/childrensmentalhealth/data.html
2. Ernstmeyer, K., & Christman, E. (Eds.). (2022). *Nursing: Mental health and community concepts*. <https://wtcs.pressbooks.pub/nursingmhcc/>
3. Centers for Disease Control and Prevention. (2022). *Data and statistics on children’s mental health*. https://www.cdc.gov/children-mental-health/data-research/?CDC_AAref_Val=https://www.cdc.gov/childrensmentalhealth/data.html

12.2 Common Disorders and Disabilities in Children and Adolescents

Mental health disorders, including substance use disorders, are common among children and adolescents in the United States, with nearly 20 percent experiencing a mental health disorder in a given year.¹ The most commonly diagnosed mental health disorders in children aged 13-17 years are attention deficit hyperactivity disorder (ADHD), anxiety problems, behavioral problems, and depression²:

- ADHD: 9.8% (approximately 6.0 million)
- Anxiety: 9.4% (approximately 5.8 million)
- Behavioral problems: 8.9% (approximately 5.5 million)
- Depression: 4.4% (approximately 2.7 million)

For adolescents, depression, substance use, and suicide are important concerns. The following statistics demonstrate these concerns in adolescents aged 12-17 years in 2018-2019, prior to the COVID-19 pandemic³:

1. Agency for Healthcare Research and Quality. (2025). *Research protocol: Implementation of recommended screening and counseling interventions to prevent mental health disorders in children and adolescents*. <https://effectivehealthcare.ahrq.gov/products/behavioral-health-screening/protocol>
2. Centers for Disease Control and Prevention. (2025). *Data and statistics on children's mental health*. https://www.cdc.gov/children-mental-health/data-research/?CDC_AAref_Val=https://www.cdc.gov/childrensmentalhealth/data.html
3. Centers for Disease Control and Prevention. (2025). *Data and statistics on children's mental health*. https://www.cdc.gov/children-mental-health/data-research/?CDC_AAref_Val=https://www.cdc.gov/childrensmentalhealth/data.html

- 36.7% had persistent feelings of sadness or hopelessness.
- 18.8% seriously considered attempting suicide; 8.9% attempted suicide.
- 15.1% had a major depressive episode.
- 4.1% had a substance use disorder.
- 1.6% had an alcohol use disorder.

After the COVID-19 pandemic, the Centers for Disease Control and Prevention (CDC) found an 8% increase in persistent feelings of sadness in youth.⁴

These common disorders, as well as developmental disabilities, tics and Tourette syndrome, substance misuse, and gender dysphoria will be discussed in this section. Autism, another type of neurodevelopmental disorder, is discussed in the “[Autism Spectrum Disorder](#)” section.

Attention Deficit Hyperactivity Disorder

ADHD is a neurodevelopmental disorder characterized by persistent patterns of inattention, hyperactivity, and impulsivity that interfere with functioning or development. It is one of the most common neurodevelopmental disorders of childhood. It is usually first diagnosed in childhood and often lasts into adulthood.⁵ Young males are diagnosed more frequently than females. See Figure 12.1⁶ for an image depicting a child struggling with symptoms of ADHD in school.

- Centers for Disease Control and Prevention. (2022). *New CDC data illuminate youth mental health threats during the COVID-19 pandemic* [Press Release]. <https://www.cdc.gov/media/releases/2022/p0331-youth-mental-health-covid-19.html>
- Centers for Disease Control and Prevention. (2024). *About attention-deficit/hyperactivity disorder (ADHD)*. https://www.cdc.gov/adhd/about/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/adhd/facts.html
- “sad-gad250898b_1920” by [Patrick Audet](#) at [Pixabay.com](#) is licensed under [CC0](#)



Figure 12.1 Child Struggling With Symptoms of ADHD in School

Signs and Symptoms

It is normal for children to exhibit challenging behaviors and have trouble focusing at certain times. However, children with ADHD often have more severe symptoms that cause difficulties at school, at home, or with friends⁷:

- Daydreaming
- Forgetting or losing things
- Squirming or fidgeting
- Talking too much
- Making careless mistakes or taking unnecessary risks
- Difficulty resisting temptation
- Difficulty getting along with others

Diagnosing a child with ADHD is a process requiring several steps by a mental

7. Centers for Disease Control and Prevention. (2024). *About attention-deficit/hyperactivity disorder (ADHD)*. https://www.cdc.gov/adhd/about/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/adhd/facts.html

health professional. There is no single test to diagnose ADHD, and many other problems such as anxiety, depression, sleep problems, and learning disorders can have similar symptoms as ADHD. The diagnostic process includes a medical exam; hearing and vision tests; and a checklist rating ADHD symptoms completed by parents, teachers, and the child.⁸ These symptoms must be present in two or more settings (e.g. home, school) and cause significant impairment in social, academic, or occupational functioning.

Types of ADHD

There are three subcategories of ADHD, determined by which symptoms are most prominent in the individual⁹:

- **Predominantly Inattentive Presentation:** This involves difficulty organizing or completing tasks, focusing on details, or following instructions and conversations.” The person is easily distracted or forgets details of daily routines. These behaviors are often misunderstood by others, who might label them as ‘laziness’ or a lack of attention.
- **Predominantly Hyperactive-Impulsive Presentation:** This presentation includes constant fidgeting and excessive talking. Sitting still for extended periods, such as during meals or homework, is challenging. Young children may run, jump, or climb constantly. Restlessness and impulsivity are often observed in behaviors such as interrupting others, grabbing objects, speaking at inappropriate moments, or struggling to wait their turn or follow directions. Impulsive tendencies may also

8. Centers for Disease Control and Prevention. (2024). *About attention-deficit/hyperactivity disorder (ADHD)*. https://www.cdc.gov/adhd/about/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/adhd/facts.html

9. Centers for Disease Control and Prevention. (2024). *About attention-deficit/hyperactivity disorder (ADHD)*. https://www.cdc.gov/adhd/about/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/adhd/facts.html

increase the likelihood of accidents or injuries compared to peers.

- **Combined Presentation:** This occurs when symptoms from both of the above categories are equally evident.

A person's symptoms of ADHD can change over time, and their predominant presentation may change.

Causes of ADHD

The cause(s) and risk factors for ADHD are unknown, but current research shows that genetics play an important role. In addition to genetics, other possible risk factors include the following¹⁰ :

- Brain injury
- Exposure to environmental risks (e.g., lead) during pregnancy or at a young age
- Alcohol and tobacco use during pregnancy
- Premature delivery
- Low birth weight

Research does not support popularly held views that ADHD is caused by eating too much sugar, watching too much television, or ineffective parenting. Many of these factors may worsen symptoms, especially in genetically predisposed people, but the evidence is not strong enough to conclude that they are the main causes of ADHD.¹¹ Recent studies have

10. Centers for Disease Control and Prevention. (2024). *About attention-deficit/hyperactivity disorder (ADHD)*. https://www.cdc.gov/adhd/about/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/adhd/facts.html

11. Centers for Disease Control and Prevention. (2024). *About attention-deficit/hyperactivity disorder (ADHD)*. https://www.cdc.gov/adhd/about/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/adhd/facts.html

explored the role of diet in ADHD, yielding mixed findings. While research does not support the widely held belief that excessive sugar intake, excessive screen time, or ineffective parenting directly cause ADHD, certain dietary factors may influence symptom severity. Notably, a “few foods diet” which eliminates potential allergens or hypersensitivity-triggering foods has shown a strong correlation with symptom improvement in some children. This suggests that food allergies or intolerances may play a role in ADHD symptoms for a subset of individuals. However, further research is needed to establish causation.¹²

While the exact cause of attention-deficit/hyperactivity disorder (ADHD) is not fully understood, research suggests that several potential contributing factors may also play a role in its development. Genetic factors appear to be significant, as children with a family history of ADHD or other mental health conditions, such as anxiety or mood disorders, may have an increased risk. Environmental influences—including early exposure to trauma, chronic family conflict, or major life transitions like divorce or relocation—might also contribute to the expression of ADHD symptoms. Additionally, possible differences in brain chemistry and structure have been studied, particularly imbalances in neurotransmitters like dopamine and norepinephrine, and irregularities in brain circuits such as those involving the prefrontal cortex and amygdala. It is important to recognize that these are potential causes and that ADHD is likely the result of a complex interplay of genetic, environmental, and neurological factors rather than any single trigger.¹³

12. Lange, K. W., Lange, K. M., Nakamura, Y., & Reissmann, A. (2023). Nutrition in the management of ADHD: A review of recent research. *Current Nutrition Reports*, 12(3), 383-394. [doi: 10.1007/s13668-023-00487-8](https://doi.org/10.1007/s13668-023-00487-8)
13. Kowalchuk, A., Gonzalez, S. J., & Zoorob, R. J. (2022). Anxiety disorders in children and adolescents. *American Family Physician*, 106(6), 657-664. <https://pubmed.ncbi.nlm.nih.gov/36521463/>

Treatments for ADHD

The treatment for childhood or adolescent Attention Deficit Hyperactivity Disorder (ADHD) is not curative; it primarily focuses on managing symptoms and improving functional outcomes. The Society for Developmental and Behavioral Pediatrics emphasizes that treatment should focus on areas of functional impairment and include ongoing, scheduled monitoring throughout the client's lifespan.

Management of ADHD typically involves a combination of pharmacologic and non-pharmacologic treatments tailored to the individual needs of the child or adolescent.

BEHAVIORAL THERAPY AND PSYCHOTHERAPY

Behavioral interventions are a cornerstone of ADHD treatment, particularly for younger children. For preschool-aged children (4–5 years old), parent training in behavior management (PTBM) is recommended as the first line of treatment before considering medication, according to the Centers for Disease Control and Prevention. PTBM and behavioral classroom interventions are strongly recommended by the American Academy of Pediatrics and the American Academy of Family Physicians. These strategies are especially effective when combined with pharmacologic treatments. ADHD can significantly affect a child's ability to pay attention, sit still, and maintain relationships with family members and peers due to disruptive behaviors. Psychotherapy can help improve behavior, self-control, and self-esteem.

In addition to behavioral interventions, cognitive-behavioral therapy (CBT) is beneficial, especially for adolescents, helping them develop coping strategies and enhance executive functioning. Educational interventions, such as Individualized Education Programs (IEPs) and 504 plans, provide tailored academic support to help children with ADHD succeed in school.

Complementary and alternative medicine approaches—such as omega-3 fatty acid supplementation, dietary modifications (e.g., elimination of artificial

food colorings), and regular physical activity—have shown some efficacy in symptom management. Finally, neurofeedback and cognitive training aim to improve attention and executive functioning through structured programs, though the evidence supporting these methods remains limited.^{14, 15}

Read more in the “[Psychological Therapies and Behavioral Interventions](#)” section of this chapter.

PARENT EDUCATION ABOUT BEHAVIORAL MANAGEMENT

Nurses can teach parents strategies for managing the behavior of their child or adolescent with ADHD¹⁶:

- **Create a routine.** Try to follow the same schedule every day, from wake-up time to bedtime.
- **Get organized.** Encourage your child to put school bags, clothing, and toys in the same place every day so that they will be less likely to lose them.
- **Manage distractions.** Limit screentime, limit noise, and provide a clean

14. Chan, E., Fogler, J. M., & Hammerness, P. G. (2016). Treatment of attention-deficit/hyperactivity disorder in adolescents: A systematic review. *JAMA*, 315(18), 1997-2008. [doi: 10.1001/jama.2016.5453](https://doi.org/10.1001/jama.2016.5453).

15. Catalá-López, F., Hutton, B., Núñez-Beltrán, A., Page, M. J., Ridao, M., Macías Saint-Gerons, D., Catalá, M. A., Tabarés-Seisdedos, R., & Moher, D. (2016). The pharmacological and non-pharmacological treatment of attention deficit hyperactivity disorder in children and adolescents: A systematic review with network meta-analyses of randomised trials. *PLoS One*, 12(7):e0180355. [doi: 10.1371/journal.pone.0180355](https://doi.org/10.1371/journal.pone.0180355).

16. Centers for Disease Control and Prevention. (2024). *About attention-deficit/hyperactivity disorder (ADHD)*. https://www.cdc.gov/adhd/about/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/adhd/facts.html

workspace when your child is doing homework. Some children with ADHD learn better if they are moving or listening to background music.

- **Limit choices.** To help your child avoid feeling overwhelmed or overstimulated, offer only a few options, such as letting them choose between two outfits, meals, or toys.
- **Be clear and specific when you talk with your child.** Let your child know you are listening by describing what you heard them say. Use clear, brief directions when they need to do something.
- **Help your child plan.** Break down complicated tasks into simpler, shorter steps. For long tasks, starting early and taking breaks may help limit stress.
- **Use goals and praise or other rewards.** Use a chart to list goals and track positive behaviors, and then let your child know they have done well by telling them or by rewarding their efforts in other ways. Be sure the goals are realistic because progress towards small steps is important to maintain a child's self-esteem.
- **Discipline effectively.** Instead of scolding, yelling, or spanking, use effective directions, time-outs, or removal of privileges as consequences for inappropriate behavior.
- **Create positive opportunities.** Children with ADHD may find certain situations stressful. Discovering and encouraging what your child does well, whether it's school, sports, art, music, or play, can help create positive experiences.
- **Provide a healthy lifestyle.** Nutritious food, lots of physical activity, and sufficient sleep are important for preventing ADHD symptoms from getting worse.
- **Communicate regularly with teachers.** Clear, regular communication between teachers and parents helps reinforce behavior management strategies at school and at home.

Parents can also be referred to ADHD support groups in the following box.

Support Groups for ADHD

- ▶ **CHADD**: Information and resources on ADHD, including treatment options, local support groups for clients and parents, and online support communities
- ▶ **Attention Deficit Disorder Association (ADDA)**: Information and resources on ADD for adults living with the disorder, including support groups and workshops
- ▶ **Psychology Today Support Groups**: Support groups near you for ADHD and other conditions

PHARMACOTHERAPY

Medication may be prescribed to help children aged six and older manage their ADHD symptoms and help them control behaviors that cause difficulties with family, friends, and at school.¹⁷

Before medications are initiated, a comprehensive medical exam including height, weight, blood pressure, heart rate, and cardiovascular history should be performed. A pretreatment baseline should be established for common side effects such as appetite, sleep, headaches, and abdominal pain. Adolescent clients should also be assessed for substance use.¹⁸

17. Centers for Disease Control and Prevention. (2024). *About attention-deficit/hyperactivity disorder (ADHD)*. https://www.cdc.gov/adhd/about/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/adhd/facts.html

18. Krull, K. R. (2022). Attention deficit hyperactivity disorder in children and adolescents: Treatment with medications. *UpToDate*. www.uptodate.com

The choice of medication by the prescriber depends on many factors, such as the following¹⁹ :

- Duration of coverage (e.g., desired coverage for school day plus completion of homework)
- The desire to avoid medication administration at school
- The ability of the child to swallow pills or capsules
- Coexisting emotional or behavioral conditions
- History of substance abuse in the client or a household member (i.e., stimulants with less abuse potential are prescribed)
- Expense
- Preferences of the child and their caregivers

Stimulants

Stimulants such as methylphenidate (Ritalin), dextroamphetamine (Dexedrine), and dextroamphetamine-amphetamine (Adderall) are considered first-line treatment because of rapid onset of action and a long record of safety and efficacy. Stimulants are available in short-, intermediate-, and long-acting formulations. The exact mechanism of action of stimulants in ADHD is unknown, but they are known to affect the dopaminergic and noradrenergic systems, causing a release of catecholamines. Stimulants have been found to improve caregiver-child interactions, aggressive behavior, and academic productivity.²⁰

Stimulants are controlled substances and require a Schedule II prescription.

19. Krull, K. R. (2022). Attention deficit hyperactivity disorder in children and adolescents: Treatment with medications. *UpToDate*. www.uptodate.com

20. Krull, K. R. (2022). Attention deficit hyperactivity disorder in children and adolescents: Treatment with medications. *UpToDate*. www.uptodate.com

CNS stimulants, including methylphenidate and amphetamine-like substances, have a high potential for abuse and dependence. The risk of abuse by the client or their family members should be assessed prior to prescribing stimulants, and signs of abuse and dependence should be evaluated while the client is receiving therapy.²¹

Side Effects

Stimulants may cause minor side effects that resolve when dosage levels are lowered, or a different stimulant is prescribed. The most common side effects include the following^{22,23}:

- Difficulty falling asleep or staying asleep
- Loss of appetite and weight loss
- Stomach pain
- Headache

Less common side effects include motor or verbal tics (sudden, repetitive movements or sounds) or personality changes (such as appearing “flat” or without emotion).²⁴ Sudden death, stroke, and myocardial infarction have

21. National Institutes of Health. (n.d.). *Black box warning*. U.S. National Library of Medicine. <https://www.nlm.nih.gov/>
22. National Institute of Mental Health. (2016). *Mental health medications*. U.S. Department of Health & Human Services. <https://www.nimh.nih.gov/health/topics/mental-health-medications>
23. National Institutes of Health. (n.d.). *Black box warning*. U.S. National Library of Medicine. <https://www.nlm.nih.gov/>
24. National Institute of Mental Health. (2016). *Mental health medications*. U.S. Department of Health & Human Services. <https://www.nimh.nih.gov/health/topics/mental-health-medications>

been reported in adults with CNS-stimulant treatment at recommended doses. Sudden death has been reported in pediatric clients with structural cardiac abnormalities and other serious heart problems taking CNS stimulants at recommended doses. If paradoxical worsening of symptoms or other adverse reactions occur, the provider should be contacted, and the dosage reduced or discontinued. Stimulants are contraindicated in clients using a monoamine oxidase inhibitor (MAOI) or using an MAOI within the preceding 14 days.²⁵

Nurses should be aware there is a possibility of diversion or misuse of stimulants by adolescents or their caregivers. Up to 29 percent of school- and college-aged students with stimulant prescriptions have been asked to give, sell, or trade their medication.²⁶

Selective Norepinephrine Reuptake Inhibitors

Selective norepinephrine reuptake inhibitors (SNRIs) such as atomoxetine (Strattera) are an alternative to stimulants for clients who experience side effects with stimulants. They may also be helpful in treating concurrent depressive or anxiety disorders. SNRIs are not controlled substances, so they may be prescribed for adolescents (or their family members) with substance use disorders. The dosage depends on the child's weight, and the duration of action is 10 to 12 hours. Atomoxetine has a Black Box Warning about increased risk of suicidal thinking in children and adolescents.²⁷

- 25. National Institutes of Health. (n.d.). *Black box warning*. U.S. National Library of Medicine. <https://www.nlm.nih.gov/>
- 26. Krull, K. R. (2022). Attention deficit hyperactivity disorder in children and adolescents: Treatment with medications. *UpToDate*. www.uptodate.com
- 27. Krull, K. R. (2022). Attention deficit hyperactivity disorder in children and adolescents: Treatment with medications. *UpToDate*. www.uptodate.com

Alpha-2 Adrenergic Agonists

Alpha-2 adrenergic agonists such as clonidine are typically used when children respond poorly to stimulants or SNRIs, have unacceptable side effects, or have significant coexisting conditions.

CLIENT AND PARENT EDUCATION

There are several important client education topics to provide to clients and/or the parents of minor children²⁸:

- **Medication information:** Discussing the purpose, potential side effects, and the importance of adherence to prescribed treatments.
- **Controlled Substance Status/High Potential for Abuse and Dependence:** Stimulants are a controlled substance by the FDA that can be abused and lead to dependence. Stimulants should be stored in a safe (preferably locked) place to prevent misuse and should not be shared with anyone. Unused or expired stimulants should be disposed of based on state law and regulations or returned to a medicine take-back program if it is available in the community.
- **Cardiovascular Risks:** Stimulants can increase blood pressure and pulse rate. Potential serious cardiovascular risks include sudden death, cardiomyopathy, myocardial infarction, stroke, and hypertension. Instruct clients to contact a health care provider immediately if they develop symptoms, such as exertional chest pain, dizziness, or passing out.
- **Suppression of Growth:** Stimulants may cause slowing of growth in children and weight loss.
- **Psychiatric Risks:** Stimulants can cause psychosis or manic symptoms, even in clients who have no prior history of these symptoms.
- **Priapism:** Painful or prolonged penile erections can occur; seek immediate medical attention.

28. National Institutes of Health. (n.d.). *Black box warning*. U.S. National Library of Medicine. <https://www.nlm.nih.gov/>

- **Alcohol:** Alcohol should be avoided.

Nurses should reinforce with the client and their family members that the reason for the prescribed medication is to help with self-control and the ability to focus. Possible side effects should be reviewed, and clients and their family members should be reminded it may take one to three months to determine the best pharmacological treatment, dose, and frequency of medication administration. During this time, the child's symptoms and adverse effects will be monitored weekly and the medication dose adjusted accordingly.²⁹

ADHD Into Adulthood

ADHD lasts into adulthood for at least one third of children with ADHD. Treatments for adults can include medication, psychotherapy, or a combination of treatments.³⁰

Anxiety

Some anxiety is a normal part of childhood and occurs at predictable stages of development. For example, from approximately age 8 months through the preschool years, healthy children may show anxiety when separated from their parents or caregivers. Young children also commonly have fears, such as fear of the dark, storms, animals, or strangers.³¹ Anxiety is functional and

29. Krull, K. R. (2022). Attention deficit hyperactivity disorder in children and adolescents: Treatment with medications. *UpToDate*. www.uptodate.com

30. Centers for Disease Control and Prevention. (2024). *About attention-deficit/hyperactivity disorder (ADHD)*. https://www.cdc.gov/adhd/about/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/adhd/facts.html

31. American Academy of Child & Adolescent Psychiatry. (2017). *Anxiety and*

normal human emotion when situational. Consider the fear of dangerous situations such as approaching a rattlesnake or standing on a steep cliff; at crucial times anxiety is important because it provides safety.

Anxiety is also motivational as it drives adolescents to accomplish goals such as passing a test by working hard and studying. **Anxiety disorders** are a group of mental health conditions characterized by excessive fear or worry that interferes with daily activities. Common types include Generalized Anxiety Disorder (GAD), Social Anxiety Disorder, and Panic Disorder. Symptoms can be persistent and may manifest physically and emotionally. Anxiety disorders in children and adolescents are characterized by excessive fear, worry, or avoidance behaviors that are disproportionate to the actual threat and impair daily functioning.

Read more about “[Adverse Childhood Experiences](#)” in the “Trauma, Abuse, and Violence” chapter.

Symptoms of Anxiety Disorders in Children and Adolescents

Children with anxiety disorders are overly tense or fearful; some may seek lots of reassurance; and their worries may interfere with daily activities. Because anxious children may also be quiet, compliant, and eager to please, their feelings of anxiety can be easily missed. When a child does not outgrow the typical fears and anxieties in childhood or when there are so many fears and worries they interfere with school, home, or play activities, the child may be diagnosed with an anxiety disorder. Examples of symptoms related to

children. https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/The-Anxious-Child-047.aspx

different types of anxiety disorders in children and adolescents include the following³²:

- Being very afraid when away from parents or caregivers (i.e., **separation anxiety**)
- Having extreme fear about a specific thing or situation, such as dogs, insects, or going to the doctor (i.e., phobias)
- Being very afraid of school and other places where there are people (i.e., social anxiety)
- Being very worried about the future and about bad things happening (i.e., general anxiety)
- Having repeated episodes of sudden, unexpected, intense fear associated with symptoms like fast heart rate, trouble breathing, dizziness, GI issues, or shakiness (i.e., panic disorder)

Anxiety can also cause irritability, anger, fatigue, headaches, stomachaches, or trouble sleeping.³³

Treatment of Anxiety Disorders in Children and Adolescents

Early treatment of anxiety disorders in children can enhance friendships, social and academic potential, and self-esteem. Interprofessional treatments often include a combination of individual psychotherapy and behavioral therapy, family therapy, medications, and consultations with the child's

32. Centers for Disease Control and Prevention. (2024). *About children's mental health*. <https://www.cdc.gov/children-mental-health/about/index.html>

33. Centers for Disease Control and Prevention. (2024). *About children's mental health*. <https://www.cdc.gov/children-mental-health/about/index.html>

school.³⁴ The goal of treatment for anxiety disorders in children and adolescents, is to reduce the severity of anxiety symptoms, improve functional impairment, and enhance overall quality of life. Overall, the treatment approach should be individualized, taking into account the severity of symptoms, the specific anxiety disorder, and the child's developmental level. When a child is overly worried or anxious, a nurses' initial assessment should determine if conditions in the child's environment are causing this feeling. For example, is the anxiety resulting from being bullied or from adverse childhood experiences (ACEs)? If so, protective interventions should be put into place. If no realistic threat exists and the anxiety causes significant prolonged life dysfunction, then the child should be referred to a health provider to determine if an anxiety disorder exists.³⁵

Read more about psychological and behavioral treatments for children and adolescents in the “[Psychological Therapies and Behavioral Interventions](#)” section.

PHARMACOTHERAPY

Pharmacotherapy primarily involves the use of selective serotonin reuptake inhibitors (SSRIs), which have been shown to be effective and well-tolerated in children and adolescents with anxiety disorders. The American Academy of Child and Adolescent Psychiatry recommends SSRIs for clients aged 6 to 18 years with social anxiety, generalized anxiety, separation anxiety, or panic disorder. Common SSRIs used include fluoxetine, sertraline, and escitalopram.

34. Centers for Disease Control and Prevention. (2024). *About children's mental health*. <https://www.cdc.gov/children-mental-health/about/index.html>

35. Hilt, R. J., & Nussbaum, A. M. (Eds.). (2016). *DSM-5 pocket guide for child and adolescent mental health*. <https://doi.org/10.1176/appi.books.9781615370511>

In cases of moderate to severe anxiety, a combination of CBT and SSRIs may be more effective than either treatment alone.^{36,37}

CLIENT AND FAMILY EDUCATION

Effective client and family education is essential in the treatment of anxiety disorders in children and adolescents, as it empowers caregivers and young clients with the knowledge, skills, and support needed to manage symptoms, adhere to treatment plans, and promote long-term mental wellness. Key components of an effective education plan include:

- **Understanding Anxiety:** Educating about the anxiety disorders and their symptoms, treatment options, and the importance of early intervention.
- **Coping Strategies:** Providing techniques for managing anxiety, including relaxation exercises and time management.
- **Medication Guidance:** Discussing the role of medications, potential side effects and benefits, and the importance of adherence to treatment plans.
- **Support Resources:** Connecting families with mental health resources, support groups, and counseling services for additional help. The role of CBT. Collaborative decision-making and providing resources such as written materials and reputable online information can support families in managing the condition.

36. Connolly, S. D., Suarez, L., & Sylvester, C. (2011). Assessment and treatment of anxiety disorders in children and adolescents. *Current Psychiatry Reports*, 13(2), 99-110. [doi: 10.1007/s11920-010-0173-z](https://doi.org/10.1007/s11920-010-0173-z).

37. Nicotra, C. M., Strawn, J. R. (2023). Advances in pharmacotherapy for pediatric anxiety disorders. *Child and Adolescent Psychiatric Clinics of North America*, 32(3), 573-587. [doi: 10.1016/j.chc.2023.02.006](https://doi.org/10.1016/j.chc.2023.02.006).

Read additional information about anxiety disorders and associated treatments in the “[Anxiety Disorders](#)” chapter. Post-traumatic stress disorder (PTSD) can develop in children or adolescents who have experienced a shocking, frightening, or dangerous event. It has similar symptoms to severe anxiety. Read more in the “[Post-Traumatic Stress Disorder](#)” section of the “Anxiety Disorders” chapter. There is also an association between obsessive-compulsive disorder (OCD) and children who have been exposed to trauma. Read more in the “[Obsessive-Compulsive Disorder](#)” section of the “Anxiety Disorders” chapter.

Depression

Every person feels sad occasionally. However, persistent sadness, hopelessness, withdrawal, or loss of interest in previously enjoyed activities may indicate depression. If these symptoms last for two or more weeks, a depressive disorder may be diagnosed. **Depression**, also known as Major Depressive Disorder (MDD), is a mood disorder characterized by persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities, and various emotional and physical problems that interfere with daily functioning. It can affect how individuals think, feel, & handle daily activities, & may lead to physical symptoms.³⁸

Symptoms of Depressive Disorders in Children and Adolescents

Examples of behaviors observed in children and adolescents with a depressive disorder are as follows³⁹:

- Feeling sad, hopeless, or irritable most of the time

38. Centers for Disease Control and Prevention. (2024). *About children’s mental health*. <https://www.cdc.gov/children-mental-health/about/index.html>

39. American Academy of Child & Adolescent Psychiatry. (2017). *Anxiety and children*. https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/The-Anxious-Child-047.aspx

- Not wanting to do or enjoy fun things
- Showing changes in eating patterns (e.g., eating a lot more or a lot less than usual)
- Showing changes in sleep patterns (e.g., sleeping a lot more or a lot less than normal)
- Showing changes in energy (e.g., being tired and sluggish or tense and restless most of the time)
- Difficulty paying attention
- Feeling worthless, useless, or guilty
- Engaging in self-injury or self-destructive behavior
- Having suicidal thoughts or making a plan for suicide
- Exhibiting physical complaints, such as frequent headaches or stomach aches
- Using alcohol or drugs as a way of trying to feel better

Depression might also cause a child to appear unmotivated or act out, causing others to incorrectly label the child as “lazy” or a “trouble-maker.”⁴⁰

It is important to ask children and adolescents who are withdrawn or sad about self-harm risks. Adolescents may perceive a single disappointment (such as a relationship break-up) as so catastrophic they feel suicidal or begin to hurt themselves.⁴¹

Causes of Depression

The cause of depression is not always known. Depression can be hereditary but can also be situational or environmental. Some causes of depression are increased stress, death of a family member or close friend, social media, and

40. Centers for Disease Control and Prevention. (2024). *About children's mental health*. <https://www.cdc.gov/children-mental-health/about/index.html>

41. Hilt, R. J., & Nussbaum, A. M. (Eds.). (2016). *DSM-5 pocket guide for child and adolescent mental health*. <https://doi.org/10.1176/appi.books.9781615370511>

bullying. Having other conditions such as attention problems, learning disorders, anxiety, or conduct disorders create a higher risk for depression.⁴² Potential causes can be categorized as the following:

- **Genetic Factors:** A family history of depression or other mood disorders
- **Environmental Stressors:** Traumatic events, significant life changes (e.g., loss, divorce), or chronic stress may contribute.
- **Biological Factors:** Neurochemical imbalances in the brain, hormonal changes, and physical health conditions can also play a role.

Treatment of Depressive Disorders in Children and Adolescents

First-line treatments for mild to moderate depression in children and adolescents typically include cognitive behavioral therapy (CBT) and interpersonal therapy (IPT). For moderate to severe cases, a combination of psychotherapy and pharmacotherapy is often recommended.

- **Psychotherapy:** CBT is widely used to help young individuals identify and reframe negative thought patterns, build coping skills, and reduce depressive symptoms.
- **Interpersonal Therapy (IPT):** IPT focuses on enhancing interpersonal relationships and social functioning, which are often disrupted by depression.
- **Lifestyle Modifications:** Encouraging regular physical activity, balanced nutrition, and healthy sleep habits can play a supportive role in improving mood and overall well-being.

If depression is suspected, a nurse, school counselor, or other frontline

42. American Academy of Child & Adolescent Psychiatry. (2017). *Anxiety and children*. https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/The-Anxious-Child-047.aspx

professional can collaborate with the child's parents or guardians to refer the child to a qualified mental health provider. A comprehensive assessment should guide treatment planning, which may include individual therapy, family-focused behavioral interventions, and coordination with the child's school to support progress. In more severe cases, antidepressant medications may be prescribed in combination with therapy to achieve better outcomes.

Read more about behavioral treatments in the "[Psychological Therapies and Behavioral Interventions](#)" section.

Pharmacotherapy

Pharmacologic treatment for depression in children and adolescents is typically reserved for moderate to severe cases and should be guided by a thorough clinical evaluation. The only FDA-approved antidepressants for pediatric use are fluoxetine (Prozac) for children aged 8 and older and escitalopram (Lexapro) for those aged 12 and older. These medications, both selective serotonin reuptake inhibitors (SSRIs), have demonstrated effectiveness but must be prescribed with caution due to the increased risk of suicidal thoughts and behaviors in young clients. Other SSRIs, such as sertraline and citalopram, have shown promising results in clinical studies but are not FDA-approved for this population. Close monitoring, regular follow-up appointments, and collaboration with the child's caregivers are essential when initiating or adjusting medication therapy.⁴³

Client and Family Education

Educating both the client and their family is a vital component of effectively managing depression in children and adolescents. A well-informed support

43. National Institute of Mental Health. (n.d.). *Child and adolescent mental health: Depression*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/child-and-adolescent-mental-health>

system can help recognize early signs, encourage treatment adherence, and promote a more stable and nurturing environment for recovery.

Understanding Depression: Families should be educated about what depression is, including its symptoms (such as persistent sadness, irritability, fatigue, changes in appetite or sleep, and loss of interest in activities), how it impacts daily functioning, and its potential effects on academic performance, social relationships, and self-esteem. Education should also include how to recognize warning signs of worsening depression or suicidal ideation, such as increased withdrawal, talk of hopelessness, or sudden behavioral changes. Emphasizing the importance of a supportive home environment and regular follow-up appointments helps ensure continuity of care and early intervention when needed.

Coping Strategies: Teaching children and their families healthy coping mechanisms such as mindfulness, deep breathing, journaling, physical activity, and structured routines—can enhance emotional regulation and resilience. Parents and caregivers can model and encourage stress management strategies to support recovery.

Medication Information: When pharmacotherapy is part of the treatment plan, it is essential to provide age-appropriate education about the purpose of the medication, potential side effects, and the critical importance of adhering to the prescribed regimen. Families should be encouraged to ask questions and to report any concerns or behavioral changes to the prescribing provider promptly.

Support Resources: Families should be connected to community resources, such as school-based mental health programs, peer support groups, and educational websites that provide trustworthy information. Counseling services for the child and family may also be beneficial. Providing written materials or recommending reputable online sources can help reinforce learning and offer continued support outside of clinical settings.⁴⁴

44. National Institute of Mental Health. (n.d.). *Child and adolescent mental*

Read more about depression and pharmacological treatments in the “[Depressive Disorders](#)” chapter.

Behavior Disorders

Children sometimes argue or act angry or defiant around adults. However, a behavior disorder is diagnosed when disruptive behaviors are uncommon for the child’s age, persist over time, or are severe. Two types of behavior disorders are oppositional defiant disorder and conduct disorder.⁴⁵

Oppositional Defiant Disorder

All children are oppositional from time to time, particularly when they are feeling tired, hungry, stressed, or upset. They may argue, talk back, disobey, and defy parents, teachers, or other adults. Oppositional behavior is considered a normal part of development for children two to three years of age and early adolescents. However, uncooperative and hostile behavior becomes a serious concern when it is so frequent and consistent that it stands out when compared with other children of the same age or when it significantly affects the child’s social, family, and academic life. According to the DSM-5, these behaviors must be present for at least six months to warrant clinical concern.⁴⁶

health: Depression. U.S. Department of Health and Human Services.

<https://www.nimh.nih.gov/health/topics/child-and-adolescent-mental-health>

45. American Academy of Child & Adolescent Psychiatry. (2019). *Oppositional defiant disorder*. https://www.aacap.org/aacap/families_and_youth/facts_for_families/fff-guide/Children-With-Oppositional-Defiant-Disorder-072.aspx

46. American Academy of Child & Adolescent Psychiatry. (2019). *Oppositional defiant disorder*. https://www.aacap.org/aacap/families_and_youth/

When children act out persistently causing serious problems at home, in school, or with peers, they may be diagnosed with **oppositional defiant disorder (ODD)**. Up to 16 percent of all school-age children and adolescents have ODD. ODD usually starts before 8 years of age. Individuals with ODD are more likely to act oppositional or defiant around people they know well, such as family members, a regular care provider, or a teacher.⁴⁷

Examples of ODD behaviors include the following⁴⁸:

- Often being angry or losing one's temper
- Often arguing with adults or refusing to comply with adults' rules or requests
- Often being resentful or spiteful
- Deliberately annoying others or becoming annoyed with others
- Often blaming other people for one's own mistakes or misbehavior

Many children with ODD may have coexisting conditions such as anxiety, post-traumatic stress disorder (PTSD), ADHD, autism, learning disabilities, or substance abuse. Some of these conditions may also be mistaken for ODD. See Figure 12.2⁴⁹ for an illustration of conditions that can be mistaken for ODD.

[facts_for_families/fff-guide/Children-With-Oppositional-Defiant-Disorder-072.aspx](https://www.cdc.gov/children-mental-health/about/about-behavior-or-conduct-problems-in-children.html)

47. Centers for Disease Control and Prevention. (2025). *Behavior or conduct problems in children*. <https://www.cdc.gov/children-mental-health/about/about-behavior-or-conduct-problems-in-children.html>

48. Centers for Disease Control and Prevention. (2025). *Behavior or conduct problems in children*. <https://www.cdc.gov/children-mental-health/about/about-behavior-or-conduct-problems-in-children.html>

49. "Instead of Oppositional Defiant Disorder 1 Wide.png" by MissLunaRose12 is licensed under [CC BY-SA 4.0](https://creativecommons.org/licenses/by-sa/4.0/)

Conditions and issues that could be mistaken for Oppositional Defiant Disorder



Figure 12.2 Conditions That Can Be Mistaken for Oppositional Defiant Disorder

Causes of ODD

The etiology of Oppositional Defiant Disorder (ODD) involves a complex interplay of genetic, environmental, and biological factors, with family dynamics playing a particularly significant role in the development and persistence of the disorder. According to the American Academy of Child and Adolescent Psychiatry, children with ODD typically direct their defiant and hostile behaviors toward authority figures, and these behaviors do not include the severe rule-breaking or antisocial acts seen in conduct disorder. Genetic influences, such as a family history of behavioral or mood disorders, may increase a child's vulnerability. Environmental contributors—including inconsistent parenting practices, exposure to trauma, abuse, or neglect—can also play a critical role. Additionally, biological factors, such as differences in brain function and individual temperament, may predispose some children to

exhibit oppositional and defiant behaviors more frequently or intensely than their peers.⁵⁰

TREATMENT OF ODD

Early intervention is critical to prevent the progression to more severe disorders such as conduct disorder and to mitigate long-term adverse outcomes. Treatment for ODD primarily involves behavioral therapy, focusing on improving parent-child interactions and implementing consistent discipline strategies.

Treatment of ODD includes the following⁵¹:

- Parent behavioral management training to help parents manage the child's behavior
- Individual psychotherapy to develop more effective anger management skills
- Family psychotherapy to improve communication and mutual understanding
- Cognitive behavioral therapy and other psychotherapies to decrease negativity and enhance effective problem-solving
- Social skills training to increase flexibility and improve frustration tolerance with peers

50. Lin, X., He, T., Heath, M., Chi, P., & Hinshaw, S. (2022). A systematic review of multiple family factors associated with oppositional defiant disorder. *International Journal of Environmental Research and Public Health*, 19(17), 10866. doi: [10.3390/ijerph191710866](https://doi.org/10.3390/ijerph191710866).

51. American Academy of Child & Adolescent Psychiatry. (2019). *Oppositional defiant disorder*. https://www.aacap.org/aacap/families_and_youth/facts_for_families/fff-guide/Children-With-Oppositional-Defiant-Disorder-072.aspx

Medications are not recommended as first-line treatment but may be used to address comorbid conditions, which can, in turn, alleviate ODD symptoms. They may be prescribed to control distressing symptoms of ODD, as well as symptoms related to coexisting conditions such as ADHD, anxiety, and mood disorders.⁵²

Parent Education

Parents of children diagnosed with ODD need support and understanding. Nurses can teach parents to help their child with ODD in the following ways⁵³:

- **Understanding ODD:** Educating families disorder, symptoms, & impact on functioning.
- **Build on the positives.** Give the child praise and positive reinforcement when they show flexibility or cooperation. Discipline will not work if there are no positive interactions.
- **Take a time-out or break.** If conflict with your child is progressively getting worse instead of better, take a time-out break. Demonstration of taking a break is also good modeling for the child. If the child decides to take a time-out to prevent overreacting, they should receive support for doing so.
- **Prioritize your battles.** Because the child with ODD has trouble avoiding power struggles, prioritize the things you want your child to do. For

52. American Academy of Child & Adolescent Psychiatry. (2019). *Oppositional defiant disorder*. https://www.aacap.org/aacap/families_and_youth/facts_for_families/fff-guide/Children-With-Oppositional-Defiant-Disorder-072.aspx

53. American Academy of Child & Adolescent Psychiatry. (2019). *Oppositional defiant disorder*. https://www.aacap.org/aacap/families_and_youth/facts_for_families/fff-guide/Children-With-Oppositional-Defiant-Disorder-072.aspx

example, if you give your child a time-out in their room for misbehavior, don't add time to the time-out for arguing. Instead, calmly say, "Your time will start when you go to your room." Listen when they shout, but do not shout back.

- **Set reasonable, age-appropriate limits and consequences.** Set limits and establish consequences that can be enforced consistently. For example, if a child refuses to do homework, a reasonable consequence might be losing screen time for the evening.
- **Maintain other interests.** Manage your stress with healthy life choices such as exercise and relaxation. Maintain personal interests so that managing your child with ODD doesn't take all your time and energy. Use respite care and other breaks as needed.
- **Obtain support.** Collaborate and obtain support from other adults working with your child (e.g., teachers and coaches).

Conduct Disorder

Conduct disorder (CD) is diagnosed when a child shows an ongoing pattern of aggression toward others with serious violations of rules and social norms at home, school, and with peers. These rule violations may involve breaking the law and result in arrest.⁵⁴ Adults with antisocial conduct disorder typically show symptoms of CD before age 15.⁵⁵

54. Centers for Disease Control and Prevention. (2025). *Behavior or conduct problems in children*. <https://www.cdc.gov/children-mental-health/about/about-behavior-or-conduct-problems-in-children.html>

55. Mayo Clinic. (2019). *Antisocial personality disorder*. <https://www.mayoclinic.org/diseases-conditions/antisocial-personality-disorder/symptoms-causes/syc-20353928#:~:text=Adults%20with%20antisocial%20personality%20disorder,Destruction%20of%20property>

Examples of CD behaviors are as follows⁵⁶ :

- Breaking serious rules, such as running away, staying out all night, or skipping school
- Being aggressive in a way that causes harm, such as bullying, fighting, or being cruel to animals
- Lying, stealing, or purposefully damaging other people's property

Children who exhibit these serious behaviors should receive a comprehensive evaluation and treatment by a mental health professional. Some signs of behavior problems, such as not following rules in school, can be related to learning disorders that require additional assessment and interventions. Without treatment, many youngsters with conduct disorder are likely to have ongoing problems resulting in the inability to adapt to the demands of adulthood.⁵⁷

TREATMENT FOR CD

Starting treatment early for CD is important. Research indicates the most effective treatment for younger children is behavior therapy training for parents—a therapist helps parents strengthen their relationship with the child and manage behavior effectively. For school-age children and teens, a combination of behavior therapy training that includes the child, the family,

56. Centers for Disease Control and Prevention. (2025). *Behavior or conduct problems in children*. <https://www.cdc.gov/children-mental-health/about/about-behavior-or-conduct-problems-in-children.html>

57. American Academy of Child & Adolescent Psychiatry. (2018). *Conduct disorder*. https://www.aacap.org/aacap/families_and_youth/facts_for_families/fff-guide/conduct-disorder-033.aspx

and the school is most effective.⁵⁸ Read more about treatment in the “[Psychological Therapies and Behavioral Interventions](#)” section.

Developmental Disabilities

Developmental disabilities are a group of conditions with physical, learning, language, or behavioral impairments. These conditions begin during the developmental period, may impact day-to-day functioning, and usually last throughout a person’s lifetime.⁵⁹ Research indicates about 17% of children are diagnosed with a developmental disability such as blindness, hearing loss, learning disability, intellectual disability, speech and language impairment, attention deficit hyperactivity disorder (ADHD), or autism spectrum disorder.⁶⁰

Keep in mind that having a developmental disability does not mean the person is not healthy. Being healthy means staying well so one can lead a full, active life.⁶¹

- 58. American Academy of Child & Adolescent Psychiatry. (2018). *Conduct disorder*. https://www.aacap.org/aacap/families_and_youth/facts_for_families/fff-guide/conduct-disorder-033.aspx
- 59. Centers for Disease Control and Prevention. (2021). *Increase in developmental disabilities among children in the United States*. <https://www.cdc.gov/ncbddd/developmentaldisabilities/features/increase-in-developmental-disabilities.html>
- 60. Centers for Disease Control and Prevention. (2024). *Developmental disabilities*. <https://www.cdc.gov/environmental-health-tracking/php/data-research/developmental-disabilities.html>
- 61. Centers for Disease Control and Prevention. (2024). *Developmental disabilities*. <https://www.cdc.gov/environmental-health-tracking/php/data-research/developmental-disabilities.html>

Read more information about autism in the “[Autism Spectrum Disorder](#)” section and ADHD in the “Attention Disorder and Hyperactivity Disorder” subsection presented earlier in this section.

Causes and Risk Factors

Developmental disabilities begin anytime during the developmental period and usually last throughout a person’s lifetime. Most developmental disabilities begin before a baby is born, but some can occur after birth because of injury, infection, or other factors. Many developmental disabilities are thought to be caused by a complex mix of factors including genetics, parental health and behaviors (such as maternal infections or substance use during pregnancy), complications during birth, infections the baby had very early in life, or exposure of the mother or child to high levels of environmental toxins, such as lead. However, there is no known cause for most developmental disabilities.⁶²

Diagnosis of Developmental Disabilities

Developmental disabilities are diagnosed by developmental monitoring and developmental screening through a partnership between parents and health care professionals as a child’s growth and development are monitored.

Every child should receive routine screenings for developmental delays at their well-child visits. During a well-child visit, the provider performs **developmental monitoring** by observing for signs of developmental delays and talking with parents about any concerns they might have about their child’s growth and development. If any problems are noted during

62. Centers for Disease Control and Prevention. (2024). *Developmental disabilities*. <https://www.cdc.gov/environmental-health-tracking/php/data-research/developmental-disabilities.html>

developmental monitoring, **developmental screening** is performed. Standardized tools used during developmental screening are formal questionnaires or checklists based on research that ask questions about a child's development, including language, movement, thinking, behavior, and emotions. Developmental screening can be done by a doctor or nurse but may also be performed by other professionals in health care, early childhood education, community, or school settings to determine if a child is learning as expected or if there are delays.⁶³

View an image of developmental milestones in Figure 12.3.⁶⁴

63. Centers for Disease Control and Prevention. (2024). *Developmental disabilities*. <https://www.cdc.gov/environmental-health-tracking/php/data-research/developmental-disabilities.html>

64. "Vroom-Poster_14x8.5_FNL-508" by National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention is in the [Public Domain](#)



Figure 12.3 Developmental Milestones

- View the [CDC's Developmental Milestones and Milestone Checklists PDF](#).

Types of Disorders

Based on developmental screenings, children may require further evaluation for language and speech disorders, learning disorders, and intellectual disabilities.

LANGUAGE AND SPEECH DISORDERS

Some children struggle with understanding language or speaking, and if they do not reach expected developmental milestones, it may be a sign of a

language or speech disorder. Early childhood—especially the first three years—is a critical period when the brain rapidly develops these skills. A rich environment filled with sounds, sights, and regular communication best supports this development.⁶⁵

Language development has many components. Children might have problems with one or more of the following⁶⁶ :

- **Receptive Language:** Difficulty understanding what others say due to not hearing the words (hearing loss) or not understanding the meaning of the words.
- **Expressive Language:** Difficulty communicating thoughts using language due to not knowing the words to use, not knowing how to put words together, or not being able to express the words.

Common indicators of language and speech disorders include⁶⁷ :

- **Articulation Errors:** Challenges forming specific words or sounds correctly
- **Speech Fluency Issues:** Problems with the smooth flow of words or sentences (e.g., stuttering)
- **Auditory Processing Challenges:** Struggles with interpreting the

65. Centers for Disease Control and Prevention. (2021). *Language and speech disorders in children*. <https://www.cdc.gov/nchs/products/databriefs/db205.htm>

66. Centers for Disease Control and Prevention. (2021). *Language and speech disorders in children*. <https://www.cdc.gov/nchs/products/databriefs/db205.htm>

67. Centers for Disease Control and Prevention. (2021). *Language and speech disorders in children*. <https://www.cdc.gov/nchs/products/databriefs/db205.htm>

meaning of sounds

- **Apraxia of Speech:** Inability to sequence sounds and syllables correctly to form words

Children who struggle with language may become frustrated, which can lead to acting out, appearing helpless, or withdrawing from social interactions. Language or speech disorders may also occur alongside conditions such as ADHD, anxiety, or autism.⁶⁸

If a child's speech or language appears to be delayed, it is important to first determine whether a hearing loss is contributing to the problem. Hearing loss may be subtle—for instance, it might affect only one ear or certain sound frequencies. A doctor may refer the child to a speech-language pathologist, who will evaluate the child's communication skills using spoken tests and conduct a hearing assessment. Based on this evaluation, the specialist can recommend activities to support language development at home, individual or group therapy, or further evaluation by an audiologist or developmental psychologist.⁶⁹

- ▶ For a detailed overview of what is considered typical for each age group, see the [Hearing and Communicative Development Checklist](#). This checklist outlines key milestones from birth to

68. Centers for Disease Control and Prevention. (2021). *Language and speech disorders in children*. <https://www.cdc.gov/nchs/products/databriefs/db205.htm>

69. Centers for Disease Control and Prevention. (2021). *Language and speech disorders in children*. <https://www.cdc.gov/nchs/products/databriefs/db205.htm>

- ▶ five years of age and serves as a guide for identifying potential delays.

LEARNING DISORDERS

Many children may struggle with learning certain topics or skills in school from time to time. However, when children struggle with learning specific skills over time, it can be a sign of a learning disorder. Having a **learning disorder** means that a child has difficulty in one or more areas of learning, even when their overall intelligence or motivation are not affected.⁷⁰

Some symptoms of learning disorders are as follows⁷¹:

- Difficulty telling right from left
- Reversing letters, words, or numbers, after the first or second grade
- Difficulties recognizing patterns or sorting items by size or shape
- Difficulty understanding and following instructions or staying organized
- Difficulty remembering what was just said or what was just read
- Lacking coordination when moving around
- Difficulty doing tasks with the hands, like writing, cutting, or drawing
- Difficulty understanding the concept of time

70. Centers for Disease Control and Prevention. (2021). *Learning disorders in children*. <https://www.cdc.gov/ncbddd/childdevelopment/learning-disorder.html>

71. Centers for Disease Control and Prevention. (2021). *Learning disorders in children*. <https://www.cdc.gov/ncbddd/childdevelopment/learning-disorder.html>

Examples of learning disorders include the following⁷²:

- **Dyslexia:** Difficulty with reading
- **Dyscalculia:** Difficulty with math
- **Dysgraphia:** Difficulty with writing

Children with learning disorders often experience frustration, which may lead to acting out, withdrawing, or exhibiting low self-esteem. These challenges can coexist with conditions such as ADHD or anxiety, further complicating academic success. Early detection and specialized instruction—such as individualized education programs (IEPs), targeted tutoring, or classroom accommodations—are key to helping these children overcome their difficulties and achieve their full potential. If difficulties persist for at least six months despite additional support, an evaluation by educational and health professionals is recommended.⁷³

INTELLECTUAL DISABILITIES

Intellectual disability is defined in the *Diagnostic and Statistical Manual of Mental Disorders (DSM5)* as a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains. The following criteria must be met for an individual to be diagnosed with an intellectual disability⁷⁴:

72. Centers for Disease Control and Prevention. (2021). *Learning disorders in children*. <https://www.cdc.gov/ncbddd/childdevelopment/learning-disorder.html>

73. Centers for Disease Control and Prevention. (2021). *Learning disorders in children*. <https://www.cdc.gov/ncbddd/childdevelopment/learning-disorder.html>

74. American Psychiatric Association. (2013). *Desk reference to the diagnostic criteria from DSM-5*.

- Deficits in intellectual functions, such as reasoning, problem-solving, planning, abstract thinking, judgment, academic learning, and learning from experience that is confirmed by both clinical assessment and individualized, standardized intelligence testing.
- Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments such as home, school, work, and the community.
- Onset of intellectual and adaptive deficits occurs during the developmental period.

Levels of intellectual disability vary greatly in children. Children with an intellectual disability might have a hard time communicating their needs, and an intellectual disability can cause them to develop more slowly than other children of the same age. Intellectual disability can be caused by a problem that starts any time before birth to when a child turns 18 years old. It can be caused by injury, disease, or other dysfunction in the brain. For many children, the cause of their intellectual disability is not known.⁷⁵

The more severe the degree of intellectual disability, the earlier the signs can be noticed during developmental monitoring, such as the following⁷⁶ :

- Sitting up, crawling, or walking later than other children
- Talking later than other children or having trouble speaking

⁷⁵. Centers for Disease Control and Prevention. (2021). *Facts about intellectual disabilities in children* [PDF]. https://www.cdc.gov/ncbddd/actearly/pdf/parents_pdfs/intellectualdisability.pdf

⁷⁶. Centers for Disease Control and Prevention. (2021). *Facts about intellectual disabilities in children* [PDF]. https://www.cdc.gov/ncbddd/actearly/pdf/parents_pdfs/intellectualdisability.pdf

- Difficulty remembering things
- Difficulty understanding social rules
- Difficulty seeing the results of their actions
- Difficulty solving problems

The severity of intellectual disability (ID) varies widely and is classified based on the level of support an individual needs in daily life. Both the DSM-5 and the American Association on Intellectual and Developmental Disabilities (AAIDD) describe four levels of severity: mild, moderate, severe, and profound.⁷⁷

Most individuals with ID fall into the mild to moderate range. These individuals typically develop conceptual, social, and daily living skills more slowly than their peers. However, with minimal to moderate support, they can learn practical life skills, communicate effectively, and often live semi-independently. Challenges may include difficulty with reading, managing money, or understanding time, but many can succeed in school and work with proper accommodations.

Severe intellectual disability is characterized by major developmental delays. Individuals in this category may understand some spoken language but have limited verbal communication skills. They often require significant support and supervision in their daily routines and may need help with hygiene, safety, and social interaction. A structured and supportive environment is essential for their well-being.

Profound ID is typically associated with congenital or genetic syndromes. These individuals require extensive support in nearly all areas of life. They have very limited communication abilities and often rely on gestures, sounds, or assistive technology to interact. Around-the-clock care is usually needed, and they benefit greatly from sensory-based therapies and consistent routines.

⁷⁷. American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>

Signs of more severe intellectual disability often appear earlier in childhood. These may include delays in motor milestones (such as sitting, crawling, or walking), limited speech or language development, problems with memory, and difficulty understanding social rules or solving problems. Early identification and intervention are key to helping children with ID reach their full potential.⁷⁸

Intellectual disabilities (ID) can arise from a complex interplay of genetic and environmental factors. Genetic conditions, such as Down syndrome and fragile X syndrome, are well-known contributors. Environmental influences—ranging from prenatal exposures to harmful substances, poor maternal nutrition, and birth complications—also play a significant role. Despite advances in research, the exact cause of an intellectual disability is not always identifiable, making comprehensive assessment essential for effective support planning.

Assessment of ID typically includes standardized tests to measure intellectual functioning, such as the Wechsler Intelligence Scale for Children, as well as evaluations of adaptive behavior, like those conducted with the Vineland Adaptive Behavior Scales. These tools help professionals understand how well an individual manages everyday tasks in comparison to their peers. The results not only confirm a diagnosis but also inform the level and type of support a person may require across various settings.

Treatment for intellectual disabilities centers around three primary areas. First, addressing underlying causes is essential in cases where conditions like metabolic disorders (e.g., phenylketonuria) can be managed through specific interventions such as dietary adjustments. Second, treating comorbid medical or psychiatric conditions is critical. Many individuals with ID also experience issues like epilepsy, attention-deficit/hyperactivity disorder

78. Centers for Disease Control and Prevention. (2022). *Facts about intellectual disability*. <https://www.cdc.gov/ncbddd/developmentaldisabilities/facts-about-intellectual-disability.html>

(ADHD), or anxiety, which may be managed through medications and psychosocial support. Third, enhancing adaptive skills is a major focus. Interventions may include early behavioral therapy, specialized education programs, and life skills training designed to promote independence and improve day-to-day functioning.

Treatment plans for individuals with ID are highly personalized and must adapt over time as needs change. While intellectual disability is typically a lifelong condition, early and targeted interventions have been shown to significantly enhance a person's quality of life, communication abilities, and capacity for independence. Multidisciplinary support and family involvement are also key factors in achieving the best possible outcomes.

Children who are suspected to have an intellectual disability based on developmental screening are referred to a developmental pediatrician or other specialist for treatment.

Tics and Tourette Syndrome

Tourette syndrome (TS) and other tic disorders affect approximately 1% of school-aged children in the United States.⁷⁹ **Tics** are sudden twitches, movements, or sounds that people do repeatedly with the inability to stop their body from doing these actions. There are two types of tics: motor and vocal. **Motor tics** are movements of the body such as blinking, shrugging the shoulders, or jerking an arm. **Vocal tics** are sounds that a person makes with his or her voice such as grunting, humming, clearing the throat, or yelling out a word or phrase. Although the media often portray people with TS as involuntarily shouting out swear words (i.e., coprolalia) or constantly repeating the words of other people (i.e., echolalia), these symptoms are rare.⁸⁰

79. Tourette Association of American. (n.d.). *What is Tourette*. <https://tourette.org/about-tourette/overview/what-is-tourette/#1461071628539-4f1f68e0-cd8d>

80. Centers for Disease Control and Prevention. (2021). *What is Tourette*

The primary symptom of Tourette syndrome (TS) is tics that typically begin when a child is 5 to 10 years old. The first symptoms are often motor tics that occur in the head and neck area. Tics are often worse during times that are stressful or exciting and tend to improve when a person is calm or focused on an activity.⁸¹

In most cases, tics decrease during adolescence and early adulthood, and sometimes disappear entirely. However, many people with TS experience tics into adulthood and, in some cases, tics can become worse during adulthood.⁸² Many individuals with TS also experience ADHD, obsessive-compulsive behaviors, anxiety, learning disabilities, behavioral issues, sleep disturbances, sensory processing issues or social difficulties. These co-occurring conditions may have a greater impact on daily life than the tics themselves. In educational settings, tailored accommodations such as private study areas, modified testing environments, or individualized instruction can be very beneficial.

Tics are typically mild and do not require treatment, but it is essential to educate the individual and others about TS and provide appropriate support across all settings (e.g., school, work, and home). When tics become

syndrome? https://www.cdc.gov/tourette-syndrome/about/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/tourette/facts.html

81. Centers for Disease Control and Prevention. (2021). *What is Tourette syndrome?* https://www.cdc.gov/tourette-syndrome/about/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/tourette/facts.html

82. Centers for Disease Control and Prevention. (2021). *What is Tourette syndrome?* https://www.cdc.gov/tourette-syndrome/about/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/tourette/facts.html

problematic or interfere with daily functioning, behavioral treatment or medication may be considered.⁸³

 View the following YouTube video of individuals with tics⁸⁴:
[Tourette Syndrome is...](#)

► To read more about Tourette syndrome and tics, go to [Tourette Association of America](#).

Substance Use Disorders

Children and adolescents may use alcohol and other substances for many reasons that may include maladaptive coping strategies or for other reasons. Alcohol is the most commonly used substance among young people in the United States. Data from several national surveys document frequent use of alcohol among young people. The 2019 Youth Risk Behavior Survey found these statistics among high school students during the past 30 days⁸⁵:

83. Tourette Association of American. (n.d.). *What is Tourette*. <https://tourette.org/about-tourette/overview/what-is-tourette/#1461071628539-4f1f68e0-cd8d>

84. Tourette Association of American. (2018, January 24). *Tourette Syndrome is...* [Video]. YouTube. All rights reserved. <https://youtu.be/M8clZP-Pl2Y>

85. Centers for Disease Control and Prevention. (2021). *Underage drinking*. https://www.cdc.gov/alcohol/underage-drinking/?CDC_AAref_Val=https://www.cdc.gov/alcohol/fact-sheets/underage-drinking.htm

- 22% Drank alcohol
- 16% Rode with a driver who has been drinking alcohol
- 5% Drove after drinking alcohol
- 17% Used electronic vapor products
- 17% Used marijuana
- 4% Smoked cigarettes

Binge drinking is defined as a pattern of alcohol consumption that brings the blood alcohol concentration level to 0.08% or more within about two hours. This pattern of drinking usually corresponds to five or more drinks on a single occasion for males or four or more drinks on a single occasion for females within about two hours.

Youth who binge drink alcohol are more likely to experience these issues⁸⁶:

- School problems, such as higher rates of absences or lower grades
- Social problems, such as fighting or lack of participation in youth activities
- Legal problems, such as arrest for driving or physically hurting someone while drunk
- Physical problems, such as hangovers or illnesses
- Unwanted, unplanned, and unprotected sexual activity
- Disruption of normal growth or sexual development
- Physical and sexual violence
- Increased risk of suicide and homicide
- Alcohol-related motor vehicle crashes and other unintentional injuries, such as burns, falls, or drowning
- Memory problems
- Misuse of other substances

86. Centers for Disease Control and Prevention. (2021). *Underage drinking*. https://www.cdc.gov/alcohol/underage-drinking/?CDC_AAref_Val=https://www.cdc.gov/alcohol/fact-sheets/underage-drinking.htm

- Changes in brain development that may have lifelong effects
- Alcohol poisoning

Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home. The 2019 National Survey on Drug Use and Health reports that approximately 20.3 million people aged 12 or older had a substance use disorder in the past year.⁸⁷

The Substance Abuse and Mental Health Services Administration (SAMHSA) has developed a national campaign called “Talk. They Hear You” to help parents and caregivers start talking with their children early about the dangers of alcohol and other drugs.⁸⁸ See Figure 12.4⁸⁹ for an example of a public service announcement from the “Talk. They Hear You” campaign.

87. Substance Abuse and Mental Health Services Administration. (2021). *Prevention of substance use and mental disorders*. <https://www.samhsa.gov/find-help/prevention>
88. Substance Abuse and Mental Health Services Administration. (2021). *Prevention of substance use and mental disorders*. <https://www.samhsa.gov/find-help/prevention>
89. “TTHY-friends-square-2020” by Substance Abuse and Mental Health Services Administration (SAMHSA) is in the Public Domain.



Figure 12.4 Image from "Talk, They Hear You" Campaign

The vulnerability to substance use disorders is shaped by a complex interplay of factors that include genetics, early experiences, environmental influences, mental health, and family relationships. A family history of substance use can increase risk due to inherited traits and learned behaviors. Initiating substance use at a young age also raises the likelihood of developing a disorder, as early exposure can interfere with brain development and decision-making. Easy access to drugs or alcohol, along with widespread advertising, can lower barriers and increase temptation, especially in communities where substance use is normalized. Mental health challenges, such as anxiety or depression, often contribute to the risk as individuals may use substances to cope with emotional distress. Additionally, family environments characterized by low parental supervision, frequent conflict, or histories of abuse and neglect can further heighten vulnerability by reducing protective supports and increasing emotional instability.

Read more information in the “[Substance Use Disorders](#)” chapter.

Gender Dysphoria

Distinctions between gender, sexual orientation, and sexual behavior are a critical concept in adolescent health and are greatly influenced by one’s culture. Sex is assigned at birth based on the medical assessment of genitalia. Anatomical characteristics and chromosomes determine whether a person is biologically male or female. Gender identity, gender roles, and gender expression are psychological and cultural constructs referring to various aspects of maleness, femaleness, or other nonbinary designation.⁹⁰

Gender identity is an individual’s innate sense of being male, female, androgynous (i.e., of indeterminate sex), nonbinary (i.e., a blend of both genders or don’t identify with either gender), or a preference to reject gender designation. An individual’s gender identity is generally established during early childhood but may evolve across their lifespan. **Gender roles** are social constructs based on masculinity and femininity that embody one’s culture’s expectations, attitudes, behaviors, and personality traits based on one’s biological sex. **Gender expression** refers to how an individual presents one’s gender to the outside world, but it does not necessarily correlate with their gender identity.⁹¹

An individual’s gender identity is influenced during early childhood by one’s parents and immediate family members defining how a person expresses themselves as members of their gender. As children become adolescents,

90. Forcier, M. (2021). Adolescent sexuality. *UpToDate*. www.uptodate.com

91. Forcier, M. (2021). Adolescent sexuality. *UpToDate*. www.uptodate.com

their influences broaden with peer, media, and community norms of gender and sexuality impacting their individual value systems.⁹²

When a person's biological sex differs from their gender identity, they experience feelings of unease about their incongruent maleness or femaleness referred to as **gender dysphoria**. For example, a biologic male with an innate sense of being female may describe himself as “a woman trapped in a man's body.”⁹³ People who are **transgender** have a gender identity or gender expression that differs from the sex they were assigned at birth. See Figure 12.5⁹⁴ for an image of a person displaying a sign at a rally for transgender equality.



Figure 12.5 Transgender Equality Rally

92. Forcier, M. (2021). Adolescent sexuality. *UpToDate*. www.uptodate.com

93. Forcier, M. (2021). Adolescent sexuality. *UpToDate*. www.uptodate.com

94. “[2013_Rally_for_Transgender_Equality_21175.jpg](#)” by [Ted Eytan](#) is licensed under [CC BY-SA 2.0](#)

According to the *DSM-5*, at least six of the following symptoms must be exhibited for at least six months and associated with distress or impaired functioning in order for a child to be diagnosed with gender dysphoria⁹⁵ :

- A strong desire to be of the other gender or an insistence they are another gender
- A strong preference for dressing in clothing stereotypical of the other gender
- A strong preference for playing with toys, games, or activities stereotypical of the other gender
- A strong rejection of the toys, games, and activities stereotypical of their assigned gender
- A strong preference for cross-gender roles when playing
- A strong preference for playmates of the other gender
- A strong dislike of one's sexual anatomy
- A strong desire to have the primary and/or secondary sex characteristics of the other gender

Only a small percentage of children who display gender dysphoria will continue to show these characteristics into adolescence or adulthood. Adolescents with gender dysphoria who dread the appearance of secondary sexual characteristics may seek hormones or surgery to alter their masculinity or femininity.⁹⁶

Sexual orientation is different from gender identity and gender expression.

95. American Psychiatric Association. (2013). *Desk reference to the diagnostic criteria from DSM-5*.

96. Forcier, M. (2021). Adolescent sexuality. *UpToDate*. www.uptodate.com

Sexual orientation refers to an individual's pattern of physical, emotional, and romantic arousal (including fantasies, activities, and behaviors) and the gender(s) of persons to whom an individual is physically or sexually attracted. An individual's assessment of their sexual orientation is termed **sexual identity**. Formation of sexual identity may be fluid with experimentation with same-gender sexual contacts as part of adolescent development. Approximately 5 to 10 percent of teens identify as lesbian, gay, or bisexual.⁹⁷

Adolescents and adults who are mature and healthy in their sexuality are able to do the following⁹⁸ :

- Take responsibility for one's own behavior
- Practice effective decision-making
- Affirm that human development includes sexual development, which may or may not include reproduction or sexual experience
- Seek further information about sexuality and reproduction as needed and make informed choices about family options and relationships
- Interact with all genders in respectful and appropriate ways
- Affirm one's own gender identity and sexual orientation and respect the gender identities and sexual orientations of others
- Appreciate one's body and enjoy one's sexuality throughout life, expressing one's sexuality in ways that are congruent with one's values
- Express love and intimacy in appropriate ways
- Develop and maintain meaningful relationships, avoiding exploitative or manipulative relationships
- Exhibit skills and communication that enhance personal relationships with family, peers, and romantic partners

Health risks and adverse outcomes can occur more readily among youth who are gender-diverse or from sexual minorities. Risks and adverse outcomes can

97. Forcier, M. (2021). Adolescent sexuality. *UpToDate*. www.uptodate.com

98. Forcier, M. (2021). Adolescent sexuality. *UpToDate*. www.uptodate.com

include child abuse, bullying, sexual harassment, teen dating violence, unprotected sex with risks for sexually transmitted infections and pregnancy, mental health problems (depression, anxiety, suicide, and disordered eating and body image), and substance use.⁹⁹

Nurses should ask all clients, including adolescents, about their gender preferences and provide support if the client indicates a need for help. By promoting sexuality as healthy, respectful, and meaningful in the global context of adolescent development, nurses can encourage a positive model of empowerment for youth exploring their gender and sexual identities.¹⁰⁰

99. Forcier, M. (2021). Adolescent sexuality. *UpToDate*. www.uptodate.com

100. Forcier, M. (2021). Adolescent sexuality. *UpToDate*. www.uptodate.com

12.3 Psychological and Behavioral Therapy

Treatment of Childhood and Adolescent Mental and Neurodevelopmental Disorders

Mental, emotional, and behavioral disorders in childhood can cause long-term problems. Early treatment of a child's mental health or behavioral problems can reduce problems at home, in school, in forming friendships, and can promote healthy development into adulthood.¹ Treatment for mental health disorders, neurodevelopmental disorders, and behavioral disorders include psychological therapy, parent training in behavioral management, and behavioral interventions for the classroom.

Psychological Therapies

Depending on the type and severity of the mental health disorder and the developmental age of the child, psychological therapy for children may be used in combination with prescribed medication. Psychological therapy helps a child manage their symptoms so that they can function well at home, in school, and in their community. For example, cognitive-behavioral therapy (CBT) works well for children with disruptive behavior disorders, depression, and anxiety.

Psychological therapy is conducted by trained mental health professionals for children and can be done individually or in groups. Psychological therapy with children can include talking, playing, or other activities to help the child express feelings and thoughts. Therapists may also observe parents and children together and make suggestions for different ways to respond to

1. Centers for Disease Control and Prevention. (2025). *Treating children's mental health with therapy*. https://www.cdc.gov/children-mental-health/treatment/?CDC_AAref_Val=https://www.cdc.gov/childrensmentalhealth/parent-behavior-therapy.html

disruptive behaviors.² See Table 12.3 for a list of psychological therapies considered effective for common conditions in children and adolescents.³

Table 12.3 Psychological Therapies for Various Conditions in Children and Adolescents

2. Centers for Disease Control and Prevention. (2025). *Treating children's mental health with therapy*. https://www.cdc.gov/children-mental-health/treatment/?CDC_AAref_Val=https://www.cdc.gov/childrensmentalhealth/parent-behavior-therapy.html
3. Hilt, R. J., & Nussbaum, A. M. (Eds.). (2016). *DSM-5 pocket guide for child and adolescent mental health*. <https://doi.org/10.1176/appi.books.9781615370511>

Therapies	Description	Indications
Cognitive-Behavioral Therapy (CBT)	Teaches clients how to correct cognitive errors in thinking (such as, “nothing ever goes right for me”) and coaches them to try different behaviors (i.e., behavioral activation) to lead to changes in how they feel. Exposure and response prevention (ERP) is a form of CBT for the treatment of obsessive-compulsive disorder (OCD).	Anxiety disorders Depressive disorders Oppositional defiant disorder Eating disorders Substance use disorder Post-traumatic stress disorder
Dialectical Behavior Therapy (DBT)	Specialized version of CBT with skills groups (to teach problem-solving, emotional regulation, distress tolerance, and interpersonal effectiveness skills), as well as individual therapy sessions. Mindfulness and meditation are often encouraged.	Chronic and significant suicide ideation and/or self-harm
Family Therapy	Sessions that focus on the family relationship or interaction patterns that cause dysfunction and assist the family members to amend that pattern (rather than saying the problem resides within an individual).	Eating disorders Conduct disorder Depressive disorders Substance use disorders
Group Therapy	Addresses interaction pattern problems while also providing disorder-specific support within a group of strangers having similar challenges. Peer-based learning can be uniquely effective.	Anxiety disorders Depression

Behavioral Management Training	Also known as parent management training, these programs teach and encourage skillful parent or caregiver responses to challenging child behaviors. Read more in the “Behavioral Interventions” subsection below.	Oppositional defiant disorder Conduct disorder
Social Skills Training	Variety of group and one-to-one techniques to teach basic behavioral and cognitive skills, reinforce prosocial behaviors, and teach social problem-solving. Group sessions are more beneficial than individual sessions because of peer learning influences.	Oppositional defiant disorder Attention deficit hyperactivity disorder (ADHD) Anxiety disorders Depressive disorders Autism spectrum disorder
Relaxation Training	Biofeedback, deep breathing, progressive muscle relaxation, and mindfulness are examples of strategies to increase mind-body awareness and enhance the ability to effectively calm emotional reactions. Read more about relaxation training in the “ Stress ” and “ Coping ” sections of the “Stress, Coping, and Crisis Intervention” chapter.	Anxiety disorders Depressive disorders

Motivational Interviewing (MI)	A specific type of therapeutic communication regarding health behaviors a client needs to change but has significant reluctance. It helps clients state their own reasons for changing behaviors, resolve their own ambivalence, and state actions they can take to change. Read more details in the “ Motivational Interviewing ” section of the “Therapeutic Communication and Nurse-Client Relationship” chapter.	Substance use disorders

Behavioral Interventions

Behavioral interventions reward desired behaviors and reduce maladaptive coping behaviors. Most child and adolescent treatment settings used structured programs to motivate and reward age-appropriate behaviors. For example, the point or star system may be used where the child receives points or stars for desired behaviors, and then specific privileges are awarded based on the points or stars earned each day.⁴

Parent Training in Behavior Management

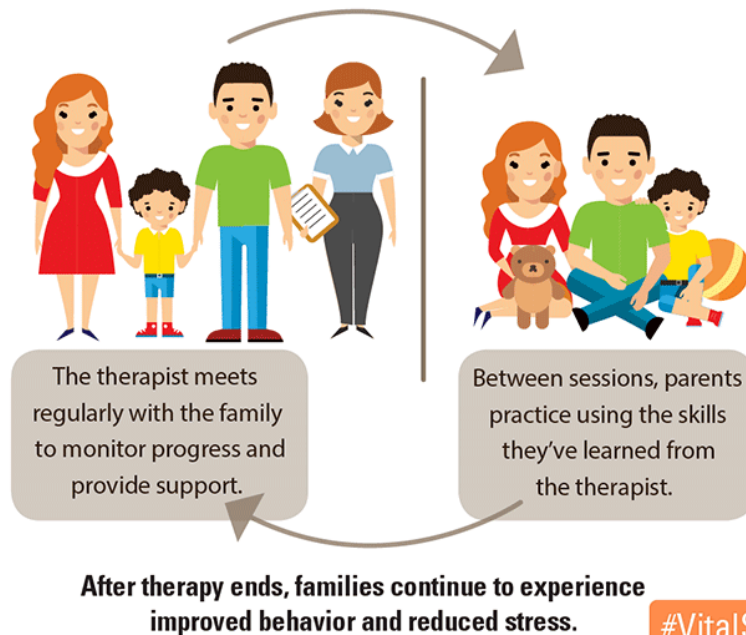
Parent training in behavior management includes teaching skills and strategies such as positive reinforcement, structure, and consistent discipline to manage their child’s behavior and help them succeed at school, at home, and in relationships.⁵

4. Halter, M. (2022). *Varcarolis’ foundations of psychiatric-mental health nursing* (9th ed.). Saunders.
5. Centers for Disease Control and Prevention. (2024). *About attention-deficit/*

See Figure 12.6⁶ for an illustration of parent training in behavioral management.

What parents can expect in behavior therapy

Parents typically attend 8-16 sessions with a therapist and learn strategies to help their child. Sessions may involve groups or individual families.



#VitalSigns

Vitalsigns™
www.cdc.gov/vitalsigns/adhd



Figure 12.6 Parent Training in Behavior Management

BEHAVIORAL MANAGEMENT STRATEGIES

There are several evidence-based strategies that nurses can teach parents and caregivers to help manage behaviors of children and adolescents, such as

hyperactivity disorder (ADHD). https://www.cdc.gov/adhd/about/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/adhd/facts.html

6. "adhd-behavior-therapy-parents-800px.png" by [National Center on Birth Defects and Developmental Disabilities](#) is in the [Public Domain](#)

Time-Out, Special Time, Functional Analysis of Behavior, Behavioral Activation, Sleep Hygiene, and Responding to Bullying.⁷

Time-Out

“Time-out” is a strategy for shaping a child’s behavior through selective and temporary removal of the child’s access to desired attention, activities, or other reinforcements following a behavioral transgression. This strategy works for children who experience regular positive praise and attention from their parents or caregivers because they feel motivated to maintain that positive regard. The length of time should be about one minute for each year of age, but adjustments need to be made based on the child’s developmental level. For example, children with developmental delays should have shorter durations.⁸

Tips for caregivers implementing time-outs include the following⁹:

- Set consistent limits to avoid confusion.
- Focus on changing priority misbehaviors rather than everything at once.
- After setting a “time-out,” decline further verbal engagement until a “time-in.”
- Ensure time-outs occur immediately after misbehavior rather than being delayed.
- Follow through if using warnings (e.g., “I’m going to count to three...”).
- State when the time-out is over. Setting a timer can be helpful.

7. Hilt, R. J., & Nussbaum, A. M. (Eds.). (2016). *DSM-5 pocket guide for child and adolescent mental health*. <https://doi.org/10.1176/appi.books.9781615370511>

8. Hilt, R. J., & Nussbaum, A. M. (Eds.). (2016). *DSM-5 pocket guide for child and adolescent mental health*. <https://doi.org/10.1176/appi.books.9781615370511>

9. Hilt, R. J., & Nussbaum, A. M. (Eds.). (2016). *DSM-5 pocket guide for child and adolescent mental health*. <https://doi.org/10.1176/appi.books.9781615370511>

- When the time-out finishes, congratulate the child on regaining personal control and then look for the next positive behavior to praise.
- Give far more positive attention than negative attention.

Special Time

“Special time” is a strategy for a caregiver and a young child to establish the enjoyment of each other’s company. It is also referred to as “child-directed play” because it emphasizes that caregivers follow the child’s lead. Tips for caregivers implementing special time include the following¹⁰ :

- Commit to setting aside a regular time for “special time.” Daily is best, but two to three times a week consistently also works.
- Select the time of day and label it as “our special time.”
- Choose a time short enough that it can happen reliably, usually 15-30 minutes. Ensure this time happens no matter how good or bad the day’s behaviors were.
- Allow the child to select the activity, which must be something you do not actively dislike or does not involve spending money or completing a chore.
- Follow the child’s lead during play, resisting the urge to tell them what to do.
- End of time; a timer may be helpful. Remind the child when the next special time will be.
- If the child refuses at first, explain you will just sit with them during the “special time.”
- Expect greater success if you set your own special times for yourself, too.

10. Hilt, R. J., & Nussbaum, A. M. (Eds.). (2016). *DSM-5 pocket guide for child and adolescent mental health*. <https://doi.org/10.1176/appi.books.9781615370511>

Functional Analysis of Behavior

Functional analysis is a strategy for preventing a recurring problematic behavior by first identifying why a behavior keeps recurring and then devising a plan to prevent recurrences. For example, a parent reports their young child “throws temper tantrums every time we go to the store.” As the mental health professional helps the parent analyze the behavior, the parent realizes they have been giving the child candy to halt the tantrums, which actually functions to reward the behavior and encourages it to happen again. If the parent were to stop delivering this unintentional reward, the tantrums would theoretically decrease. Alternatively, the parent may focus on avoiding reexposing the child to a recognized trigger for the behavior, such as the candy aisle.¹¹

Behavioral Activation

Behavioral activation is a strategy to encourage a young person to reengage with other people and do things they find pleasurable. When an individual is sad or anxious, they are less likely to engage in activities they enjoy, and this withdrawal can cause isolation and worsen the mood. The following is a list of tips to provide clients for succeeding with behavioral activation¹²:

- Identify activities that you (not others) find motivating or rewarding. Develop a list with a variety of options because repetitively doing the same thing can become boring.
- Refine the list to things that can be measured as completed rather than vague goals.

11. Hilt, R. J., & Nussbaum, A. M. (Eds.). (2016). *DSM-5 pocket guide for child and adolescent mental health*. <https://doi.org/10.1176/appi.books.9781615370511>

12. Hilt, R. J., & Nussbaum, A. M. (Eds.). (2016). *DSM-5 pocket guide for child and adolescent mental health*. <https://doi.org/10.1176/appi.books.9781615370511>

- Rank the activities in order of those most easily completed to those more difficult to complete.
- Start by selecting something easy to accomplish to get started and then work up the list in increasing level of difficulty.
- Let others know your plans and enlist their help in motivating you.

Sleep Hygiene

Insomnia is a common problem among children and adolescents. Most sleep problems can be resolved by changing habits and routines that affect sleep, commonly referred to as sleep hygiene. The following is a list of tips for caregivers for improving sleep hygiene¹³:

- Maintain consistent bedtimes and wake times every day of the week.
- Maintain a routine of pre-sleep activities (e.g., brush teeth, read a book).
- Avoid spending non-sleep time in or on one's bed. (i.e., "beds are for sleep").
- Ensure the bedroom is cool and quiet.
- Avoid highly stimulating activities just before bed (e.g., television, video games, social media, or exercise).
- Do not keep video games, televisions, computers, or phones in a child's bedroom. Set a media curfew on technology use.
- Incorporate exercise into the day in order to aid with sleep.
- Avoid caffeine in the afternoons and evenings. Caffeine causes shallow sleep and frequent awakenings.
- Encourage children and adolescents to discuss any worries with the caregiver before bed rather than ruminating on it during sleep time.
- Ensure that children go to bed drowsy but still awake. Falling asleep in places other than a bed forms habits that are difficult to break.
- Use security objects with young children who need a transitional object

13. Hilt, R. J., & Nussbaum, A. M. (Eds.). (2016). *DSM-5 pocket guide for child and adolescent mental health*. <https://doi.org/10.1176/appi.books.9781615370511>

with which to feel safe and secure when their caregiver is not present (e.g., a special blanket or toy)

- When checking on a young child at night, briefly reassure the child you are present and they are OK.
- Avoid afternoon naps for all but very young children because they often interfere with nighttime sleep.
- If a child or adolescent is having sleep difficulties, keep a sleep diary to track sleep time, wake time, activities, and naps to identify patterns.

Responding to Bullying

Bullying occurs when a person seeks to harm, intimidate, or coerce someone perceived as vulnerable. If there is a sudden change in a child's mood, behavior, sleep, body symptoms, academic performance, or social functioning, there is a possibility they are experiencing bullying. Cyberbullying is a significant public health concern with rates of cyberbullying estimates ranging from 14 to 57%.¹⁴

The following is a list of tips for assessing and responding to bullying¹⁵:

- **Detect:** Ask the child: "Sometimes kids get picked on or bullied. Have you ever seen this happen? Has it ever happened to you?" If the child responds "No" but bullying is suspected, suggest the caregivers speak with teachers and/or review the child's social media accounts.
- **Educate:** Let children know that bullying is unacceptable and if they experience bullying, you will help them respond.

14. Zhu, C., Huang, S., Evans, R., & Zhang, W. (2021). Cyberbullying among adolescents and children: A comprehensive review of the global situation, risk factors, and preventive measures. *Frontiers in Public Health*, 9. <https://doi.org/10.3389/fpubh.2021.634909>

15. Hilt, R. J., & Nussbaum, A. M. (Eds.). (2016). *DSM-5 pocket guide for child and adolescent mental health*. <https://doi.org/10.1176/appi.books.9781615370511>

- **Plan:** Plan ways with the child to avoid bullying.
 - Avoid places where bullying happens.
 - Teach them to walk away when bullying occurs and tell a trusted adult who can be quickly accessed.
 - Instruct the child to stay near adults where bullying occurs. Most bullying happens when adults are not around.
 - If a child feels they can confront the bully, teach them to say in a calm, clear voice to stop the behavior and, “Bullying is not OK.”
 - If the child is comfortable with deflating the situation with humor, they can use humor to challenge the bullying.
 - Encourage the child to ask their peers for support and ideas for dealing with the bully.
 - Encourage caregivers to communicate the bullying to the school and other families and jointly devise solutions.

► Read more information about addressing bullying at www.stopbullying.gov.

Behavioral Interventions for the Classroom

Behavioral interventions for the classroom help children and adolescents succeed academically. Behavioral classroom management is a teacher-led approach that encourages a student’s positive behaviors in the classroom through a reward system or a daily report card and discourages their negative behaviors. Organizational training teaches children and adolescents time management, planning skills, and ways to keep school materials organized to optimize student learning and reduce distractions.¹⁶

16. Centers for Disease Control and Prevention. (2024). *About attention-deficit/*

hyperactivity disorder (ADHD). https://www.cdc.gov/adhd/about/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/adhd/facts.html

12.4 Autism Spectrum Disorder

Autism spectrum disorder (ASD) is a neurodevelopmental disorder that affects an individual's communication and behavior. Although autism can be diagnosed at any age, it is classified as a developmental disorder because symptoms generally appear in the first two years of life. About 3% of children in the United States have ASD. ASD is reported in all racial, ethnic, and socioeconomic groups and is three times more common among boys.¹

ASD is characterized by the following²:

- Difficulty with communication and interaction with other people
- Restricted interests and repetitive behaviors
- Symptoms that hurt the person's ability to function properly in school, work, and other areas of life

Autism is known as a “spectrum” disorder because there is wide variation in the type and severity of symptoms experienced by individuals. ASD occurs in all ethnic, racial, and economic groups. Although ASD is a lifelong disorder, treatments and services can improve a person's symptoms and ability to

1. National Institute of Mental Health. (2025). *Autism spectrum disorder (ASD)*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/statistics/autism-spectrum-disorder-asd#part_2547
2. National Institute of Mental Health. (2025). *Autism spectrum disorder (ASD)*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/statistics/autism-spectrum-disorder-asd#part_2547

function.³ See Figure 12.7⁴ for an image depicting a child coping with the symptoms of autism.



Figure 12.7 Child Coping With Autism Symptoms

Signs and Symptoms

People with ASD have difficulty with social communication and interaction, experience restricted interests, and exhibit repetitive behaviors. Here are some examples of behaviors in these categories:

Social Communication/Interaction Behaviors⁵:

- Making little or inconsistent eye contact
- Not looking at or listening to people
- Rarely sharing enjoyment of objects or activities by pointing or showing

3. National Institute of Mental Health. (2025). *Autism spectrum disorder (ASD)*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/statistics/autism-spectrum-disorder-asd#part_2547

4. “5299266366_0b6c8ae172_o” by [hepingting](#) is licensed under [CC BY-SA 2.0](#)

5. National Institute of Mental Health. (2025). *Autism spectrum disorder (ASD)*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/statistics/autism-spectrum-disorder-asd#part_2547

things to others

- Being slow to respond (or failing to respond) to someone calling one's name
- Having difficulties with the back-and-forth nature of a conversation
- Talking at length about a favorite subject without noticing that others are not interested or without giving others a chance to respond
- Exhibiting facial expressions, movements, and gestures that do not match what is being said
- Using a tone of voice that may sound flat and robot-like
- Having trouble understanding another person's point of view or being unable to understand other people's actions

Restricted Interests or Repetitive Behaviors⁶ :

- Repeating certain behaviors or exhibiting unusual behaviors, such as repeating words or phrases (i.e., **echolalia**)
- Having a lasting intense interest in certain topics, such as numbers, details, or facts
- Having overly focused interests, such as with moving objects or parts of objects
- Getting upset by slight changes in a routine
- Being more or less sensitive than other people to sensory input, such as light, noise, clothing, or temperature
 - This sensitivity can present as physical touch, like a hug, actually being experienced as painful. Items such as seams on pants can be overwhelming and extremely agitating.

6. National Institute of Mental Health. (2025). *Autism spectrum disorder (ASD)*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/statistics/autism-spectrum-disorder-asd#part_2547

Although people with ASD experience many challenges, they may also have many strengths, including⁷:

- Being able to learn things in detail and remember information for long periods of time
- Being strong visual and auditory learners
- Excelling in math, science, music, or art

Causes and Risk Factors

Research suggests that genes can act together with influences from the environment to affect development in ways that can lead to ASD. Risk factors include the following⁸:

- A sibling with ASD
- Older parents at birth
- Genetic conditions such as Down syndrome and Fragile X syndrome
- Very low birth weight
- Gender (ASD is four times more common in boys than in girls)

Treatments

Current treatments for ASD seek to reduce symptoms that interfere with daily functioning and quality of life. ASD affects each person differently, meaning that people with ASD have unique strengths and challenges and thus

7. National Institute of Mental Health. (2025). *Autism spectrum disorder (ASD)*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/statistics/autism-spectrum-disorder-asd#part_2547
8. National Institute of Mental Health. (2025). *Autism spectrum disorder (ASD)*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/statistics/autism-spectrum-disorder-asd#part_2547

different treatment needs. Treatment plans typically involve multiple professionals with interventions customized to the individual.⁹

As individuals with ASD exit high school and grow into adulthood, additional services can help improve their health and daily functioning and facilitate social engagement. Support may be provided to complete job training, find employment, and secure housing and transportation.¹⁰

There are many categories of treatments available, and some treatments involve more than one approach. Treatment categories include the following¹¹:

- Behavioral
- Developmental
- Educational
- Social-Relational
- Pharmacological
- Psychological
- Complementary and Alternative

Behavioral Approaches

Behavioral approaches focus on changing an individual's behaviors by

9. National Institute of Mental Health. (2025). *Autism spectrum disorder (ASD)*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/statistics/autism-spectrum-disorder-asd#part_2547
10. National Institute of Mental Health. (2025). *Autism spectrum disorder (ASD)*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/statistics/autism-spectrum-disorder-asd#part_2547
11. National Institute of Mental Health. (2025). *Autism spectrum disorder (ASD)*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/statistics/autism-spectrum-disorder-asd#part_2547

promoting understanding of what happens before and after the behavior. A notable behavioral treatment for people with ASD is called applied behavior analysis. Applied behavior analysis encourages desired behaviors and discourages undesired behaviors to improve a variety of skills, and progress is tracked and measured.¹²

Developmental Approaches

Developmental approaches focus on improving specific developmental skills, such as language skills or physical skills. Developmental approaches are often combined with behavioral approaches. The most common developmental therapy for people with ASD is speech and language therapy. Speech and language therapy helps improve the person's understanding and use of speech and language. Some people with ASD communicate verbally. Others with severe symptoms of ASD may communicate through the use of signs, gestures, pictures, or an electronic communication device.¹³

Occupational therapy teaches skills to help the person live as independently as possible. Skills may include dressing, eating, bathing, and relating to other people. Occupational therapy can also include sensory integration therapy to help improve responses to sensory input that may be restrictive or overwhelming.¹⁴

12. National Institute of Mental Health. (2025). *Autism spectrum disorder (ASD)*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/statistics/autism-spectrum-disorder-asd#part_2547
13. National Institute of Mental Health. (2025). *Autism spectrum disorder (ASD)*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/statistics/autism-spectrum-disorder-asd#part_2547
14. National Institute of Mental Health. (2025). *Autism spectrum disorder (ASD)*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/statistics/autism-spectrum-disorder-asd#part_2547

Physical therapy may be implemented to help improve physical skills, such as fine movements of the fingers or larger movements of the trunk and body.¹⁵

Educational Approaches

Educational treatments are provided in a classroom setting. One type of educational approach is the Treatment and Education of Autistic and Related Communication-Handicapped Children (TEACCH) approach. TEACCH is based on the idea that people with autism thrive on consistency and visual learning. It provides teachers with ways to adjust the classroom structure to improve academic and other outcomes. For example, daily routines can be written and placed in clear sight, boundaries can be set around learning stations, and verbal instructions can be complemented with visual instructions or physical demonstrations.¹⁶

Social-Relational Approaches

Social-relational treatments focus on improving social skills and building emotional bonds. For example, “social stories” provide simple descriptions of what to expect in a social situation. “Social skills groups” provide opportunities for people with ASD to practice social skills in a structured environment.

Pharmacological Approaches

There are no medications used to treat ASD, but medications may be used to

15. National Institute of Mental Health. (2025). *Autism spectrum disorder (ASD)*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/statistics/autism-spectrum-disorder-asd#part_2547

16. National Institute of Mental Health. (2025). *Autism spectrum disorder (ASD)*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/statistics/autism-spectrum-disorder-asd#part_2547

treat symptoms and improve functioning. For example, medication may be used to manage high energy levels, improve focus, or limit self-harming behavior, such as head banging or hand biting. Medication may also be used to treat concurrent psychological and medical conditions, such as anxiety, depression, seizures, or sleep problems.¹⁷

Psychological Approaches

Psychological approaches can help people with ASD cope with anxiety, depression, and other mental health issues. For example, cognitive behavioral therapy (CBT) helps individuals focus on the connections between their thoughts, feelings, and behaviors. During CBT a therapist and the individual work together to identify goals and change how the person thinks about a situation to change how they react to the situation.¹⁸

Complementary and Alternative Treatments

Some individuals with ASD use special diets, herbal supplements, chiropractic care, animal therapy, art therapy, mindfulness, or relaxation therapies.¹⁹ Treatment is most effective when tailored to the individual, and additional enriching therapies can help individuals with ASD to thrive.

17. National Institute of Mental Health. (2025). *Autism spectrum disorder (ASD)*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/statistics/autism-spectrum-disorder-asd#part_2547
18. National Institute of Mental Health. (2025). *Autism spectrum disorder (ASD)*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/statistics/autism-spectrum-disorder-asd#part_2547
19. National Institute of Mental Health. (2025). *Autism spectrum disorder (ASD)*. U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/statistics/autism-spectrum-disorder-asd#part_2547

View a supplementary YouTube video²⁰ providing the
 perspectives of people with autism: [What's it like to be a person with autism? | In A Different Key | PBS](https://www.youtube.com/watch?v=GoieHK2vR50)

- ▶ To find resources related to caring for children with autism, go to the [Autism Society](#).

20. PBS. (2022, December 9). *What's it like to be a person with autism? | In A Different Key | PBS* [Video]. YouTube. All rights reserved.
<https://www.youtube.com/watch?v=GoieHK2vR50>

12.5 Applying the Nursing Process to Mental Health Disorders in Children and Adolescents

Working with children and adolescents is very different from working with adults. Young people are often reluctant participants who have been brought for care they did not seek on their own. Additionally, their communication skills are limited based on their developmental stage. In addition to gathering information from the child, information must also be obtained from the parent or caregiver.¹

The first step to successful care is to create a therapeutic nurse-client relationship. A therapeutic alliance can typically be created if the young person feels noticed, heard, and appreciated. It is often helpful to start the conversation with a relatively neutral question like, “Your mom said that you go to ____ school. What is that school like?” School, friends, family, and favorite activities are low-stress conversation starters. For a very young child, a conversation starter could be a simple observation like what they are wearing. For example, “I see you are wearing blue tennis shoes; did you pick those out yourself?”²

For young people who seem reluctant to start talking, it may be helpful to describe something you saw that shows you have been paying attention to them. For example, “It looked as though it was hard for you to sit and do nothing while your dad and I were talking. Am I right about that?”³

When caring for adolescents, it is helpful to gather data from the parent or

1. Hilt, R. J., & Nussbaum, A. M. (Eds.). (2016). *DSM-5 pocket guide for child and adolescent mental health*. <https://doi.org/10.1176/appi.books.9781615370511>
2. Hilt, R. J., & Nussbaum, A. M. (Eds.). (2016). *DSM-5 pocket guide for child and adolescent mental health*. <https://doi.org/10.1176/appi.books.9781615370511>
3. Hilt, R. J., & Nussbaum, A. M. (Eds.). (2016). *DSM-5 pocket guide for child and adolescent mental health*. <https://doi.org/10.1176/appi.books.9781615370511>

caregiver, and then ask to speak with the adolescent alone. Reinforce that the conversation is “conditionally confidential” and invite the adolescent to sit alone with you to talk. A 1:1 conversation with an adolescent typically creates a better therapeutic alliance with more honest answers obtained.⁴

A more subtle strategy to build a therapeutic-nurse relationship with children and adolescents is to shape how you speak so you are perceived as a responsive problem-solving partner rather than an authority figure who will judge them. Building a therapeutic nurse-client relationship with a young person should lead to learning their true chief complaint because the chief complaint of an adolescent may be different from their parents’ complaints.⁵ Furthermore, goal setting and treatment plans will be more effective when the adolescent’s concerns are addressed.

Privacy, Confidentiality, and Mandatory Reporting

In most regions, minors require parental or guardian consent for treatment. Adolescents may be able to provide informed consent independently for specific services, such as substance use, sexual health). Confidentiality should be balanced with safety and legal obligations.

Confidentiality should be discussed with the adolescent client and their parent/guardian before beginning an assessment or related conversations, and circumstances should be defined for when confidentiality is “conditional” for children and adolescents. State laws determine what information is considered confidential and what requires reporting to law enforcement or Child Protective Services. Examples of what must be reported to law enforcement include child abuse, gunshot or stabbing wounds, sexually transmitted infections, abortions, suicidal ideation, and homicidal ideation.

4. Hilt, R. J., & Nussbaum, A. M. (Eds.). (2016). *DSM-5 pocket guide for child and adolescent mental health*. <https://doi.org/10.1176/appi.books.9781615370511>

5. Hilt, R. J., & Nussbaum, A. M. (Eds.). (2016). *DSM-5 pocket guide for child and adolescent mental health*. <https://doi.org/10.1176/appi.books.9781615370511>

Some state laws make it optional for clinicians to inform parents/guardians if their child is seeking services related to sexual health care, substance abuse, or mental health care. Nurses should be aware of the state laws affecting the confidentiality of child and adolescent care in the state in which they are practicing.⁶

Although it is important for nurses to respect adolescent clients' privacy and confidentiality, it is also important to encourage the adolescent to talk with their parents/guardians about personal issues that affect their health even if they feel uncomfortable doing so. Parent/guardian support can help ensure the adolescent's health needs are met.⁷

Research your state's laws regarding adolescent/child clients' rights.

▶ Here is a link to [Wisconsin Department of Health Services' Client Rights for Minors](#).

Assessment (Recognizing Cues)

When assessing a child or adolescent's mental health, the nurse incorporates a variety of assessments, such as the following:

- Performing a mental status examination
- Completing a psychosocial assessment including:
 - Reviewing the client's reason for seeking healthcare

6. Middleman, A. B., & Olson, K. A. (2021). Confidentiality in adolescent health care. *UpToDate*. www.uptodate.com

7. Middleman, A. B., & Olson, K. A. (2021). Confidentiality in adolescent health care. *UpToDate*. www.uptodate.com

- Screening the client for suicidal ideation, exposure to trauma or violence, signs of self injury, and substance misuse
- Complete a cultural assessment, spiritual assessment, and assess client family dynamics
- Use of psychotropic medications (drugs that treat psychiatric symptoms) and/or other medications that can cause psychiatric symptoms as side effects
- History of mental disorders, family history of mental illness, and previous hospitalizations
- Educational background, occupational background
- Coping mechanisms and functional ability
- Reviewing specific laboratory results related to the client's use of psychotropic and other medications
- Incorporating life span and developmental considerations

Mental Status Examination

Specific signs and symptoms of a mental health disorder should be assessed as part of the “health history” component of a comprehensive nursing assessment. While asking questions about specific symptoms and obtaining a health history, the nurse should also be simultaneously performing a mental status examination. The mental status examination includes these items:

- Appearance and General Behavior
- Speech
- Motor Activity
- Affect and Mood
- Thoughts and Perceptions
- Attitude and Insight
- Cognitive Abilities

Review details of a comprehensive mental status examination in the

“Assessment” section of the “Application of the Nursing Process to Mental Health Care” chapter.

Psychosocial Assessment

A **psychosocial assessment** (also referred to as a health history) is a component of the nursing assessment process that obtains additional subjective data to detect risks and identify treatment opportunities and resources. Agencies have specific forms used for psychosocial assessments/health histories that typically consist of several components^{8,9}:

- Reason for seeking health care (i.e., “chief complaint”)
- Thoughts of self-injury or suicide
- Family dynamics
- Cultural assessment
- Spiritual assessment
- Current and past medical history
- Current medications
- History of previously diagnosed mental health disorders
- Previous hospitalizations
- Educational background
- Occupational background
- History of exposure to psychological trauma, violence, and domestic abuse

8. GW School of Medicine & Health Sciences. (n.d.). *Clinical FICA tool*.
<https://smhs.gwu.edu/spirituality-health/program/transforming-practice-health-settings/clinical-fica-tool>

9. Glasner, J., Baltag, V., & Ambresin, A. E. (2021). Previsit multidomain psychosocial screening tools for adolescents and young adults: A system review [PDF]. *Journal of Adolescent Health*, 68, 449-459.
[https://www.jahonline.org/article/S1054-139X\(20\)30600-5/pdf](https://www.jahonline.org/article/S1054-139X(20)30600-5/pdf)

- Substance use (tobacco, alcohol, recreational drugs, misused prescription drugs)
- Family history of mental illness
- Coping mechanisms
- Functional ability/Activities of daily living

Review details of a psychosocial assessment in the “[Assessment](#)” section of the “Application of the Nursing Process to Mental Health Care” chapter.

REASON FOR SEEKING HEALTH CARE

Mental health symptoms in children and adolescents often manifest differently than in adults, often through behavioral changes, school difficulties, or somatic complaints. Parents and caregivers typically bring a child or adolescent in for mental health evaluation due to common concerns, such as the following:

- Poor academic performance
- Developmental delays
- Disruptive or aggressive behavior
- Withdrawn or sad mood
- Irritable or labile mood
- Anxious or avoidant behavior
- Recurrent and excessive physical complaints
- Sleep problems
- Self-harm and suicidality
- Substance abuse
- Disturbed eating

Poor academic performance is a common concern. Keep in mind that assessing a child’s/adolescent’s ability to function in school is like assessing an adult’s ability to function at work. Many factors can affect a young person’s performance at school, such as their ability and effort, the classroom environment, life distractions, or a mental health disorder.

A child's or adolescent's academic ability may be impacted by hearing or visual impairments, learning disorders, or cognitive impairments. The nurse may assist with performing vision or hearing tests or providing a developmental rating scale.

THOUGHTS OF SUICIDE OR SELF INJURY

Suicide is a leading cause of death in adolescents. Risk may be masked by their behavior or dismissed by caregivers. As discussed in Chapter 1, all clients aged 12 and older presenting for acute care should be screened for suicidal ideation. Universal screening allows for the detection of suicide risk and implementation of early interventions before a person attempts suicide. The ASQ Suicide Risk Screening Tool is commonly used across a variety of health care settings to screen youth for suicidal ideation. ASQ questions include the following¹⁰:

1. In the past few weeks, have you wished you were dead?
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?
3. In the past week, have you been having thoughts about killing yourself?
4. Have you ever tried to kill yourself?
5. Are you having thoughts of killing yourself right now?

If client answers “No” to all questions 1 through 4, screening is complete, no interventions are necessary, and it is not necessary to ask question #5. However, clinical judgment always overrides a negative screen). If the client answers “Yes” to any of questions 1 through 4, or refuses to answer, they are considered a positive screen and question #5 should be asked to assess acuity. If the client answers “yes” to question 5, they are considered high risk and require a STAT safety/mental health evaluation. They should be kept in

10. National Institute of Mental Health. (n.d.). *Youth ASQ toolkit*.
<https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/youth-asq-toolkit>

sight at all times while a health care provider is notified. All dangerous objects should be removed from room.¹¹

Non-suicidal self-injury (NSSI) refers to intentional self-inflicted destruction of body tissue without suicidal intention and for purposes not socially sanctioned. Common forms of NSSI include behaviors such as cutting, burning, scratching, and self-hitting. It is considered a maladaptive coping strategy without the desire to die. NSSI is a common finding among adolescents and young adults in psychiatric inpatient settings.¹²

FAMILY DYNAMICS

A child's environment – including family dynamics, trauma history, and social factors – can significantly influence their mental health. Nurses assess parent-child relationships, attachment patterns, and exposure to violence, neglect, or instability. Family dynamics refers to the patterns of interactions among family members, their roles and relationships, and the various factors that shape their interactions. Because family members typically rely on each other for emotional, physical, and economic support, they are one of the primary sources of relationship security or stress. Secure and supportive family relationships provide love, advice, and care, whereas stressful family relationships may include frequent arguments, critical feedback, and unreasonable demands.¹³

11. National Institute of Mental Health. (n.d.). *Youth ASQ toolkit*. <https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/youth-asq-toolkit>
12. Cipriano, A., Cella, S., & Cotrufo, P. (2017). Nonsuicidal self-injury: A systematic review. *Frontiers in Psychology*, 8. <https://www.frontiersin.org/articles/10.3389/fpsyg.2017.01946/full>
13. Jabbari, B., Schoo, C., & Rouster, A. S. (2023). *Family dynamics*. StatPearls [Internet]. <https://www.ncbi.nlm.nih.gov/books/NBK560487>

Interpersonal interactions among family members have lasting impacts and influence the development and well-being of children. Unhealthy family dynamics can cause children to experience trauma and stress as they grow up, known as adverse childhood experiences (ACEs). Conflict between parents and adolescents is associated with adolescent aggression, whereas mutuality (cohesion and warmth) is shown to be a protective factor against aggressive behavior.¹⁴

- ▶ Review information on adverse childhood experiences (ACEs) in the “[Mental Health and Mental Illness](#)” section of Chapter 1.

Effectively assessing and addressing a client’s family dynamics and its role in a child’s or adolescent’s mental health disorder requires an interprofessional team of health professionals, including nurses, physicians, social workers, and therapists. Nurses are in a unique position to observe interaction patterns, assess family relationships, and attend to family concerns in clinical settings because they are in frequent contact with family members. Collaboration among interprofessional team members promotes family-centered care and provides clients and families with the necessary resources to develop and maintain healthy family dynamics.¹⁵

Signs of abuse, neglect, or bullying are important for the nurse to observe and report. Read more about abuse and neglect in the “[Trauma, Abuse, and Violence](#)” chapter.

14. Jabbari, B., Schoo, C., & Rouster, A. S. (2023). *Family dynamics*. StatPearls [Internet]. <https://www.ncbi.nlm.nih.gov/books/NBK560487>
15. Jabbari, B., Schoo, C., & Rouster, A. S. (2023). *Family dynamics*. StatPearls [Internet]. <https://www.ncbi.nlm.nih.gov/books/NBK560487>

- Read more information about family dynamics in the “[Family Dynamics](#)” chapter of *Open RN Nursing Health Promotion*.

CULTURAL CONSIDERATIONS

The Cultural Formulation Interview (CFI) is a structured tool in the *DSM-5* used to assess the influence of culture on a client’s experience of distress. See the following box for an adapted version of the CFI tool for children and adolescents.¹⁶

Adapted Cultural Formulation Interview for Children and Adolescents¹⁷

- **Suggested introduction to the child or adolescent:** We have talked about the concerns of your family. Now I would like to know how you are feeling about being ____ years old.
- **Feelings of age appropriateness in different settings:** Do you feel you are like other people your age? In what way? Do you sometimes feel different from other people your age? In what way?

¹⁶. Jabbari, B., Schoo, C., & Rouster, A. S. (2023). *Family dynamics*. StatPearls [Internet]. <https://www.ncbi.nlm.nih.gov/books/NBK560487>

¹⁷. Jabbari, B., Schoo, C., & Rouster, A. S. (2023). *Family dynamics*. StatPearls [Internet]. <https://www.ncbi.nlm.nih.gov/books/NBK560487>

- If they acknowledge sometimes feeling different: Does this feeling of being different happen more at home, at school, at work, and/or some other place? Do you feel your family is different from other families? Does your name have special meaning for you? Is there something special about you that you like or are proud of?
- **Age-related stressors and supports:** What do you like about being at home? At school? With friends? What don't you like at home? At school? With friends? Who is there to support you when you feel you need it? At home? At school? Among your friends?
- **Age-related expectations:** What do your parents or grandparents expect from a person your age in terms of chores, schoolwork, play, or religion? What do your teachers expect from a person your age? What do other people your age expect from a person your age? (If they have siblings, what do your siblings expect from a person your age?)
- **Transition to adulthood (for adolescents):** Are there any important celebrations or events in your community that recognize reaching a certain age or growing up? When is a youth considered ready to become an adult in your family or community? What is good about becoming an adult in your family? In school? In your community? How do you feel about "growing up"? In what ways are your life and responsibilities different from your parents' life and responsibilities?

LIFE SPAN AND DEVELOPMENTAL CONSIDERATIONS

Children and adolescents are actively experiencing cognitive, emotional, and social development. Young children may lack the vocabulary to describe complex emotions. Nurses use developmentally appropriate language, play therapy, and visual aids to facilitate communication and consider that adolescents may express their feelings through risk-taking or withdrawal. Review theories of development across the life span in the “[Application of the Nursing Process in Mental Health Care](#)” chapter.

Adolescence is a time of exploration regarding gender identity, gender roles, and sexual orientation. As previously discussed, assuring conditional confidentiality is the first step in establishing basic trust and a therapeutic nurse-client relationship with an adolescent client. Most adolescents require privacy to talk candidly about their gender identity and sexuality, so parents/guardians should be asked to leave the examination room at some point during the visit.¹⁸

Diagnosis (Analyzing Cues)

Health care professionals use the guidelines in the American Psychiatric Association's *Diagnostic and Statistical Manual (DSM-5)* to diagnose mental health disorders in children.¹⁹

Nurses customize nursing diagnoses based on the child's or adolescent's response to mental health disorders, their current signs and symptoms, and

18. Middleman, A. B., & Olson, K. A. (2021). Confidentiality in adolescent health care. *UpToDate*. www.uptodate.com

19. American Psychiatric Association. (2013). *Desk reference to the diagnostic criteria from DSM-5*.

the effects on their and their family's functioning. Here are common nursing diagnoses related to childhood and adolescent mental health disorders^{20,21,22}.

- Anxiety
- Chronic Low Self-Esteem
- Disabled Family Coping
- Impaired Social Interactions
- Ineffective Impulse Control
- Risk for Delayed Development
- Risk-prone Health Behavior
- Risk for Impaired Parenting
- Risk for Spiritual Distress

Outcome Identification (Generate Solutions)

Broad goals focus on reducing symptoms of mental health disorders that interfere with the child's or adolescent's daily functioning and quality of life. SMART outcomes stand for outcomes that are specific, measurable, achievable, and realistic with a timeline indicated. They are customized according to each client's diagnoses and needs. Read more about SMART outcomes in the "[Application of the Nursing Process in Mental Health Care](#)" chapter.

For example, a SMART outcome for a child diagnosed with attention deficit hyperactivity disorder is, "The client will demonstrate reduced impulsive

20. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.
21. Ackley, B., Ladwig, G., Makic, M. B., Martinez-Kratz, M., & Zanotti, M. (2020). *Nursing diagnosis handbook: An evidence-based guide to planning care* (12th ed.). Elsevier.
22. Herdman, T. H., & Kamitsuru, S. (Eds.). (2018). *Nursing diagnoses: Definitions and classification, 2018-2020*. Thieme Publishers New York.

behaviors, as reported by parents and their teachers, within two weeks of initiating stimulant medication.”

Planning (Generate Solutions)

Interventions can be planned by nurses for children and adolescents in a variety of settings, including inpatient, outpatient, day treatment, outreach programs in schools, and home visits. Nurses use collaborative, respectful approaches that involve the youth in goal-setting. They involve parents and caregivers as appropriate, but empower the child’s or adolescent’s voice and participation in their care.²³

Safety

Safety receives top priority when planning and implementing interventions for pediatric clients at risk of suicide, and interventions are planned according to their level of risk and developmental level. Review interventions for clients at risk of suicide in the “[Application of the Nursing Process in Mental Health Care](#)” chapter.

It is helpful to encourage older children and adolescents to generate a list of personal warning signs (e.g., thoughts, behaviors, situations, emotional states) that typically precede suicidal thoughts, with as much specificity as possible. These warning signs serve as a cue that it is time for them to use their safety plan. As compared with adults, youths may focus more on general emotional states (e.g., sadness, anger) or external triggers, such as interpersonal situations. Pediatric clients are encouraged to generate a list of coping strategies they can employ to distract themselves from suicidal thoughts and a list of trusted individuals to ask for help during a suicidal crisis. Nurses also work with parents and caregivers to make the client’s

23. Halter, M. (2022). *Varcarolis’ foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

environment safe and limiting access to means for suicide, such as firearms, medications, knives, and potential household poisons.²⁴

Prevention

A public health approach to children's mental health includes promoting mental health for all children, providing preventative measures for children at risk, and implementing interventions.²⁵

It is not known why some children develop disruptive behavior disorders, but children are at greater risk if they are exposed to **adverse childhood experiences (ACEs)**. Toxic stress from ACEs can alter brain development and affect how the body responds to stress. ACEs are linked to chronic health problems, mental illness, and substance abuse. Children with three or more reported ACEs, compared to children with zero reported ACEs, had higher prevalence of one or more mental, emotional, or behavioral disorders (36.3% versus 11.0%).²⁶ Review information on adverse childhood experiences (ACEs) in the “[Mental Health and Mental Illness](#)” section of Chapter 1.

Preventing ACEs can help children thrive into adulthood by lowering their risk

24. Pettit, J. W., Buitron, V., & Green, K. L. (2018). Assessment and management of suicide risk in children and adolescents. *Cognitive and Behavioral Practice*, 25(4), 460–472. <https://doi.org/10.1016/j.cbpra.2018.04.001>
25. Centers for Disease Control and Prevention. (2021). *Therapy to improve children's mental health*. https://www.cdc.gov/children-mental-health/treatment/?CDC_AAref_Val=https://www.cdc.gov/childrensmentalhealth/parent-behavior-therapy.html
26. Centers for Disease Control and Prevention. (2022). *Data and statistics on children's mental health*. https://www.cdc.gov/children-mental-health/data-research/?CDC_AAref_Val=https://www.cdc.gov/childrensmentalhealth/data.html

for chronic health problems and substance abuse, improve their education and employment potential, and stop ACEs from being passed from one generation to the next.²⁷

Raising awareness about ACEs can help reduce stigma around seeking help for parenting challenges, substance misuse, depression, or suicidal thoughts. Community solutions focus on promoting safe, stable, nurturing relationships and environments where children live, learn, and play. In addition to raising awareness and participating in community solutions, nurses should recognize ACE risk factors and refer clients and their families for effective services and support. See Figure 12.8²⁸ regarding strategies to prevent ACEs.

27. Centers for Disease Control and Prevention. (2019). *Adverse childhood experiences (ACEs)*. <https://www.cdc.gov/vitalsigns/aces/index.html>

28. This image is derived from “[Preventing Adverse Childhood Experiences \(ACEs\): Leveraging the Best Available Evidence](#)” by [National Center for Injury Prevention and Control, Division of Violence Prevention PDF](#) and is in the [Public Domain](#)



Preventing ACEs

Strategy	Approach
Strengthen economic supports to families	• Strengthening household financial security • Family-friendly work policies
Promote social norms that protect against violence and adversity	• Public education campaigns • Legislative approaches to reduce corporal punishment • Bystander approaches • Men and boys as allies in prevention
Ensure a strong start for children	• Early childhood home visitation • High-quality child care • Preschool enrichment with family engagement
Teach skills	• Social-emotional learning • Safe dating and healthy relationship skill programs • Parenting skills and family relationship approaches
Connect youth to caring adults and activities	• Mentoring programs • After-school programs
Intervene to lessen immediate and long-term harms	• Enhanced primary care • Victim-centered services • Treatment to lessen the harms of ACEs • Treatment to prevent problem behavior and future involvement in violence • Family-centered treatment for substance use disorders

Figure 12.8 Strategies to Prevent ACEs

- ▶ Read [Preventing Adverse Childhood Experiences PDF](#) by the CDC with evidence-supporting interventions.

Implementation (Take Action)

Treatment of mental health disorders in children and adolescents typically requires a combination of psychotherapy and pharmacotherapy. Read about specific multidisciplinary treatments for various disorders in the “[Psychological Therapies and Behavioral Intervention](#),” and “[Autism Spectrum](#)

[Disorder](#)” sections of this chapter. Nurses recognize and capitalize on the client’s and family’s strengths as they develop a nursing care plan and provide education and referral to resources as appropriate. A variety of interventions may be implemented based on the disorder diagnosed and the developmental level of the child or adolescent.

Behavioral Interventions

Behavioral interventions reward desired behaviors to reduce maladaptive coping behaviors. Most child and adolescent treatment settings use structured programs to motivate and reward age-appropriate behaviors. For example, the point or star system may be used where the child receives points or stars for desired behaviors, and then specific privileges are awarded based on the points or stars earned each day.²⁹

Read more about interprofessional behavioral interventions for the child, parents/caregivers, and teachers in the “[Psychological Therapies and Behavioral Interventions](#)” section.

Play Therapy

Children develop physically, intellectually, emotionally, and socially through play. **Play therapy** encourages children to express feelings such as anxiety, self-doubt, and fear through their natural play. It also allows them to work through painful or traumatic memories. For example, nurses often use dolls or other toys to help children work through feelings of fear prior to a medical

29. Halter, M. (2022). *Varcarolis’ foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

procedure.³⁰ See Figure 12.9³¹ for an image of children with special needs playing at a school for autism.



Figure 12.9 Children With Special Needs Playing at an Autism School

Bibliotherapy

Bibliotherapy uses books to help children express feelings in a supportive environment, gain insight into feelings and behavior, and learn new ways to cope with difficult situations. When children listen to or read a story, they identify with the characters and experience a catharsis of feelings. Stories and books should be selected based on the child's cognitive and developmental levels that reflect the situations or feelings the child is experiencing and their

30. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

31. "4885680339_721cd1843e_k" by [World Bank Photo Collection](#) is licensed under [CC BY-NC-ND 2.0](#)

emotional readiness for the topic.³² See Figure 12.10³³ for an image of bibliotherapy.



Figure 12.10 Bibliotherapy

Expressive Arts Therapy

Art provides a nonverbal method of expressing difficult or confusing emotions. Drawing, painting, and sculpting with clay are commonly used art therapies. Children who have experienced trauma often show the traumatic event in their drawing when asked to draw whatever they wish.³⁴

32. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

33. "[Bibliotherapy.jpg](#)" by [Shelley Rodrigo](#) is licensed under [CC BY 2.0](#)

34. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

Journaling

Journaling is an effective technique for older children and teenagers. Journaling is a tangible way to record emotions and begin dialogue with others. A daily journal is also helpful in setting goals and evaluating progress.³⁵

Music Therapy

Music has been recognized for centuries as having healing power. **Music therapy** is an evidence-based approach to improve an individual's physical, psychological, cognitive, behavioral, and social functioning when listening to music, singing, or moving to music.³⁶ See Figure 12.11³⁷ for an image of music therapy.

35. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

36. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

37. "[103909417_f36b60ceec_k](#)" by [midiman](#) is licensed under [CC BY 2.0](#)



Figure 12.11 Music Therapy

Family Education and Support

Education of family members is a key component for treating child and adolescent mental health disorders. Read more about “Parent Training in Behavior Management” in the “[Psychological Therapies and Behavioral Interventions](#)” section. Nurses can help family members develop specific goals and identify interventions to achieve their family’s goals.

Family members can also be encouraged to attend support groups or group education. Group education can be useful for learning how other families solve problems and build on strengths while developing insight and improved judgment about their own family.³⁸

- ▶ Find support groups for many disorders near you at [Psychology Today’s Support Groups](#).

38. Halter, M. (2022). *Varc Carolis’ foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

Disruptive Behavior Management

Nurses can manage a child's or adolescent's disruptive behaviors by implementing many different types of interventions³⁹ :

- **Behavioral contract:** A verbal or written agreement is made between the client and other parties (e.g., nurses, parents, or teachers) about behaviors, expectations, and needs. The contract is periodically reviewed with positive and negative reinforcement provided.
- **Collaborative and proactive solutions:** The identification of problematic behaviors, their specific triggers, and mutually agreeable solutions.
- **Role playing:** The nurse or client acts out a specific role to practice new behaviors or skills in specific situations.
- **Planned ignoring:** When behaviors are determined to be attention-seeking and not dangerous, they may be ignored. Positive reinforcement is provided for on-task actions.
- **Signals or gestures:** An adult uses a word, gesture, or eye contact to remind the child to use self-control. For example, placing one's finger to one's lips and making eye contact may be used to remind a child to remain quiet during a quiet activity.
- **Physical distance:** It may be helpful to move closer to a child for a calming effect. However, some children may find this agitating and require more space and less physical closeness.
- **Redirection:** The engagement of an individual in an appropriate activity after an undesirable action.
- **Humor:** Appropriate joking can be used as a diversion to help relieve feelings of guilt or fear.
- **Restructuring:** The process of changing an activity to reduce stimulation or frustration.
- **Limit setting:** The process of giving direction, stating an expectation, or

39. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

telling a child what to do or where to go. Caregivers and/or staff should do this firmly, calmly, and consistently without anger, preferably in advance of problem behavior occurring. For example, “I would like you to stop turning the light on and off.”

- **Simple restitution:** The individual is expected to correct the adverse effects of their actions, such as apologizing to the people affected or returning upturned chairs to their proper position.

Restrictive Interventions

Restrictive interventions are only implemented after attempting less restrictive interventions that did not successfully manage the client's behavior. As a last resort, restrictive interventions, including seclusion or restraints, may be implemented to keep the client or others around them safe.⁴⁰

The Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC) define seclusion as the involuntary confinement of a client alone in a room or area from which the client is physically prevented from leaving. Restraint is defined as any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a client to move their arms, legs, body, or head freely. A drug is considered a restraint when it is used as a restriction to manage the client's behavior or restrict the client's freedom of movement and is not a standard treatment or dosage for the client's condition.⁴¹

40. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

41. Knox, D. K., & Holloman, G. H. (2012). Use and avoidance of seclusion and restraint: Consensus statement of the American Association for Emergency Psychiatry Project BETA seclusion and restraint workgroup. *The Western Journal of Emergency Medicine*, 13(1), 35–40. <https://doi.org/10.5811/westjem.2011.9.6867>

Seclusion is viewed as less restrictive than restraints, but seclusion and restraint are psychologically harmful and can be physically dangerous. Nurses must vigilantly follow agency policy when implementing seclusion or restraints. Members of the health care team who assist with seclusion or restraint of children or adolescents must receive specific training to decrease the risk of injury to the youngster and themselves.⁴²

Seclusion and restraints should be discontinued as soon as possible. Clients in seclusion or restraints must be frequently monitored. Hydration, elimination, comfort, and other psychological and physical needs must be monitored regularly and addressed per agency policy.⁴³

After the child or adolescent is calm, staff should include the child in a debriefing session and discuss the events leading up to the restrictive interventions to explore ways it may have been prevented.⁴⁴

Nursing Interventions for Pediatric Clients Based on Categories of the APNA Implementation Standard

Nurses implement interventions related to each subcategory of the *Implementation* Standard of Care for pediatric clients in mental health settings. See Table 12.5a for examples of common nursing interventions for each subcategory.

42. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

43. Knox, D. K., & Holloman, G. H. (2012). Use and avoidance of seclusion and restraint: Consensus statement of the American Association for Emergency Psychiatry Project BETA Seclusion and Restraint Workgroup. *The Western Journal of Emergency Medicine*, 13(1), 35–40. <https://doi.org/10.5811/westjem.2011.9.6867>

44. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

Table 12.5a Examples of Nursing Interventions for Pediatric Mental Health Disorders Based on Subcategories of APNA Implementation Standard

Subcategory of the APNA Standard of Implementation	The nurse will ...	Rationale
Coordination of Care	• Collaborate with parents/guardians, school personnel, pediatricians, and therapists to create a comprehensive care plan. • Facilitate communication between home, school, and clinical settings. • Involve child welfare services when safety is a concern.	Children and adolescents depend on parents, caregivers and school systems for stability. Coordinated care ensures continuity, consistency, and multisystem support.
Health Teaching and Health Promotion	• Provide age-appropriate psychoeducation about emotions, coping strategies, and symptom management. • Teach families about diagnoses, developmental expectations, and the impact of trauma or stress. • Promote healthy sleep, nutrition, and physical activity routines.	Understanding mental health supports empowerment, reduces stigma, and improves engagement in care. Teaching families promotes a supportive home environment.

Pharmacological, Biological, and Integrative Therapies	• Administer psychotropic medications as prescribed, with careful monitoring of side effects, growth, and development. • Educate children and families about medications using simple, clear language. • Integrate play, mindfulness, or expressive therapies to support emotional regulation.	Children may not understand or tolerate medications the same as adults. Combining medication with developmentally appropriate therapies enhances safety and efficacy.
Milieu Therapy	• Maintain a structured, supportive, and trauma-informed environment. • Use consistent routines and clearly defined behavioral expectations. • Model and reinforce positive behaviors through praise and positive reinforcement strategies.	Children need structure and predictability for emotional security. A therapeutic milieu promotes self-regulation and reduces acting-out behaviors.

Therapeutic Relationship and Counseling	• Build trust through play, nonjudgmental listening, and consistent presence. • Use developmentally appropriate communication tools (e.g., drawing, games, storytelling). • Support identity development and emotional expression. • Engage family in therapy and encourage healthy communication.	A strong therapeutic relationship is the foundation for behavioral change, especially in youth who have experienced trauma or instability. Developmentally-appropriate therapeutic interactions foster connection and insight.

Communication Tips for Pediatric Clients with Mental Health Disorders

Communicating effectively with pediatric clients must foster feelings of trust, safety, and therapeutic alliance. Table 12.5b provides communication tips when working with pediatric clients.

Table 12.5b Communication Tips for Pediatric Clients⁴⁵

45. Halter, M. (2022). *Varcarolis’ foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

Tip	Explanation
Use developmentally appropriate language	Avoid clinical or abstract terms. Use simple, concrete words and metaphors that match the child's age and cognitive level (e.g., "worry bugs" for anxiety). This supports understanding and reduces confusion.
Use play, drawing, or storytelling as communication tools	Many children express emotions and thoughts more effectively through nonverbal activities or play that promote emotional expression while building rapport.
Maintain a calm, warm, and nonjudgmental tone	Children are sensitive to tone and body language. A calm presence helps them feel safe and promotes emotional regulation, especially during distress or behavioral outbursts.
Validate feelings, even if behaviors are inappropriate	Say things like, "It looks like you're feeling really upset right now." Validation shows empathy and teaches emotional literacy without reinforcing negative behavior.
Offer choices when possible	Providing limited, structured choices (e.g., "Would you like to talk here or in the beanbag corner?") fosters autonomy and reduces power struggles.
Be consistent and set clear expectations	Children with mental health challenges often struggle with boundaries. Clear, consistent communication reduces anxiety and helps them feel secure.
Allow time for response and silence	Children, especially those with trauma, anxiety, or neurodevelopmental conditions, may need extra time to process questions. Silence can be therapeutic and allows for reflection.
Use positive reinforcement and praise	Focus on strengths and progress (e.g., "I noticed you tried really hard to use your words instead of yelling."). Positive reinforcement promotes confidence and reinforces desired behavior.
Engage parents and caregivers in communication and modeling	Involve families in treatment goals, behavior support strategies, and shared language for emotional regulation. Consistency across settings supports skill generalization and stability.

Evaluation (Evaluate Outcomes)

Evaluation focuses on monitoring a child's and adolescent's progress towards meeting their individualized SMART goals and the revision of the nursing care plan as needed. Evaluation criteria are aligned to the specific client diagnosis. Client progress monitoring may include symptom management, behavior

management, academic performance, activities of daily living, and socialization. The nurse also monitors effectiveness of interprofessional treatments, support groups, and community resources for the client's families.

Examples of evaluation questions include:

- “How often are the symptoms occurring?”
- “Have there been any changes in the intensity of the symptoms?”
- “How are the symptoms affecting daily functioning at home, school, and in social settings?”
- “Are there any improvements in academic performance or social interactions?”
- “Have there been any changes in mood or behavior?”
- “Are there any new behaviors or worsening of previous behaviors?”
- “What changes have parents or teachers observed in the child’s behavior or emotional state?”
- “How are the symptoms of coexisting conditions being managed?”

12.6 Spotlight Application

 Dr. Temple Grandin was one of the first individuals to document the insights gained from her personal experience of autism. View the following YouTube video¹ of Dr. Temple Grandin describing her personal experience as, “Everything in my mind works like a search engine set for the image function”: [Temple Grandin on Her Search Engine | Blank on Blank](https://youtu.be/lfsh6sojAvg).

Reflective Questions

1. What symptoms of autism does Dr. Temple Grandin illustrate?
2. What strengths does Dr. Temple Grandin illustrate and what has she achieved?

1. Blank on Blank. (2016, March 1). *Temple Grandin on her search engine | Blank on Blank*. [Video]. YouTube. All rights reserved. <https://youtu.be/lfsh6sojAvg>

12.7 Learning Activities



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<https://wtcs.pressbooks.pub/nursingmhcc/?p=640#h5p-41>

1



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<https://wtcs.pressbooks.pub/nursingmhcc/?p=640#h5p-42>

2



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2. “MH Childhood and Adolescence Disorders Fill in Blank” by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)

online here:

<https://wtcs.pressbooks.pub/nursingmhcc/?p=640#h5p-44>

3

- ▶ Test your clinical judgment with a NCLEX Next Generation-style question: [Chapter 12, Assignment 1](#)⁴



- ▶ Test your clinical judgment with a NCLEX Next Generation-style case study: [Chapter 12, Case Study 1](#)⁵



3. "MH Childhood and Adolescence Disorders Question Set 1" by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)
4. "MH Childhood and Adolescence Disorders Next Gen Question 1" by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)
5. "MH Childhood and Adolescence Disorders Next Gen Case Study" by Kellea Ewen is licensed under [CC BY-NC 4.0](#)

XII Glossary

Adverse childhood experiences (ACEs): Potentially traumatic events that occur in childhood, such as violence, abuse, and growing up in a family with mental health or substance use problems.

Anxiety disorders: A group of mental health conditions characterized by excessive fear or worry that interferes with daily activities.

Bibliotherapy: A behavioral intervention that uses books to help children express feelings in a supportive environment, gain insight into feelings and behavior, and learn new ways to cope with difficult situations.

Conduct disorder (CD): A behavioral disorder diagnosed when a child shows an ongoing pattern of aggression toward others with serious violations of rules and social norms at home, school, and with peers.

Depression: A mood disorder characterized by persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities, and various emotional and physical problems that interfere with daily functioning.

Developmental disabilities: A group of conditions with physical, learning, language, or behavioral impairments.

Developmental monitoring: Routine screenings for developmental delays during well-child visits based on observations of the child and discussion with parents.

Developmental screening: Formal questionnaires or checklists based on research that ask questions about a child's development, including language, movement, thinking, behavior, and emotions.

Dyscalculia: A learning disorder with difficulty with math.

Dysgraphia: A learning disorder with difficulty with writing.

Dyslexia: A learning disorder with difficulty with reading.

Echolalia: Pathological repetition of another person's words.

Expressive language disorder: Difficulty communicating thoughts using language due to not knowing the words to use, not knowing how to put words together, or not being able to express the words.

Intellectual disability: A person's ability to learn at an expected level and function in daily life is limited.

Learning disorder: Difficulty in one or more areas of learning, even when a child's overall intelligence or motivation are not affected.

Mental health disorders among children: Serious changes in the way children typically learn, behave, or handle their emotions, causing distress and problems getting through the day.

Music therapy: A behavioral intervention to improve an individual's physical, psychological, cognitive, behavioral, and social functioning by listening to music, singing, or moving to music.

Oppositional defiant disorder (ODD): A behavioral disorder diagnosed when children act out persistently, causing serious problems at home, in school, or with peers.

Play therapy: A behavioral intervention that encourages children to express feelings such as anxiety, self-doubt, and fear through their natural play. It also allows them to work through painful or traumatic memories.

Receptive language disorder: Difficulty understanding what others say due to not hearing the words (hearing loss) or not understanding the meaning of the words.

Restraint: Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a client to move their arms, legs, body, or head freely.

Seclusion: The involuntary confinement of a client alone in a room or area from which the client is physically prevented from leaving.

Separation anxiety: A condition of children being very afraid when away from parents or caregivers.

Tics: Sudden twitches, movements, or sounds that people do repeatedly with the inability to stop their body from doing these actions.

Learning Objectives

- Identify assessment cues of eating disorder behaviors
- Identify nursing priorities for clients with eating disorders
- Plan outcomes for clients with eating disorders
- Differentiate safety/protective interventions for clients with eating disorders
- Apply evidence-based practice when planning care and interventions for clients with eating disorders
- Analyze treatments for clients with eating disorders
- Apply the nursing process to clients with eating disorders at risk for suicide

Many individuals experience concerns about their weight at some point in their lives. However, eating disorders involve a distorted perception of weight and body image, leading to an unhealthy relationship with food. This psychological struggle can result in behaviors such as extreme food restriction, compulsive exercise, binge eating, and purging. Eating disorders can affect people of any gender, age, race, or socioeconomic background and often have a profound impact on their loved ones. Without proper identification and treatment, the physiological consequences can be life-threatening. This chapter explores the various types of eating disorders, common assessment findings, treatment approaches, and nursing interventions.

13.2 Basic Concepts

Eating disorders are severe mental health conditions characterized by significant disturbances in eating behaviors and related thoughts and emotions. These disorders can have profound impacts on physical, psychological, and social functioning. The most common types of eating disorders include anorexia nervosa, bulimia nervosa, and binge eating disorder.

The way we talk about eating disorders with others matters.¹ See Figure 13.1² with facts nurses can use to help shape the conversation around eating disorders.

1. National Institute of Mental Health. (2024). *Eating disorders*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/eating-disorders>
2. “[2020_eatingdisorderinfographics_final.jpg](#)” by U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health is in the [Public Domain](#)



Figure 13.1 Facts About Eating Disorders

Common Eating Disorders

Common eating disorders include anorexia nervosa, bulimia nervosa, and binge eating disorder.³ Individuals may have more than one type of disorder.

Anorexia Nervosa

Anorexia nervosa is a condition where people avoid food, severely restrict food, or eat very small quantities of only certain foods. They have an intense

3. National Institute of Mental Health. (2024). *Eating disorders*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/eating-disorders>

fear of gaining weight or becoming fat, even if they are significantly underweight. People with anorexia nervosa often have distorted body image and view themselves as overweight.⁴ See Figure 13.2⁵ for an illustration of how a person with anorexia nervosa may perceive themselves.

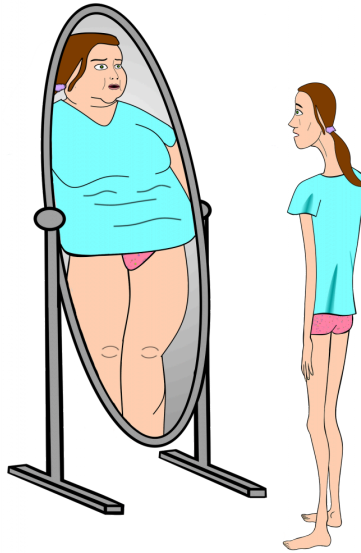


Figure 13.2 Body Perception of a Person With Anorexia Nervosa

There are two subtypes of anorexia nervosa^{6,7}:

- **Restricting Type:** Individuals severely limit the amount and type of food

4. National Institute of Mental Health. (2024). *Eating disorders*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/eating-disorders>
5. “Bulimia-Anorexia-Nervosa-Skimmed-Delusional-4049661.png” by unknown author is licensed under CC0.
6. National Institute of Mental Health. (2024). *Eating disorders*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/eating-disorders>
7. American Psychiatric Association. (2013). *Desk reference to the diagnostic criteria from DSM-5*.

they consume and may engage in excessive exercise.

- **Binge-Eating/Purging Type:** Individuals experience episodes of binge eating and/or purging.
 - **Binge eating** involves consuming large amounts of food in a short period with a sense of loss of control.
 - **Purging** refers to self-induced vomiting or the misuse of laxatives, diuretics, or enemas to eliminate consumed food.

Anorexia nervosa can be fatal due to medical complications associated with starvation. It has an extremely high mortality (death) rate compared with other mental health disorders. Young people between the ages of 15 and 24 with anorexia have 10 times the risk of dying compared to their same-aged peers. Males represent 25% of individuals with anorexia nervosa and are at a higher risk of dying because they are often diagnosed later than females.^{8,9}

Signs and symptoms of anorexia nervosa include the following¹⁰:

- Severely restricted eating
- Extreme thinness (also referred to as **emaciation**)
- A relentless pursuit of thinness and unwillingness to maintain a healthy weight
- Intense fear of gaining weight

8. National Institute of Mental Health. (2024). *Eating disorders*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/eating-disorders>

9. National Eating Disorders Association. (n.d.). *Statistics and research on eating disorders*. <https://www.nationaleatingdisorders.org/statistics-research-eating-disorders>

10. National Institute of Mental Health. (2024). *Eating disorders*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/eating-disorders>

- Distorted body image where a person's self-esteem is heavily influenced by their perception of their of body weight and shape
- Denial of the seriousness of low body weight

Other signs may develop over time, including these issues¹¹:

- Thinning of the bones (i.e., osteopenia or osteoporosis)
- Anemia
- Muscle wasting and weakness
- Brittle hair and nails
- Dry and yellowish skin
- Growth of fine hair all over the body (**lanugo**)
- Severe constipation
- Low blood pressure
- Slowed breathing and pulse
- Drop in internal body temperature, causing the person to feel cold all the time
- Lethargy, sluggishness, or feeling tired all the time
- Infertility
- Damage to the structure and function of the heart
- Brain damage
- Multiorgan failure

See the following box for criteria used to diagnose anorexia nervosa according to the *Diagnostic and Statistical Manual of Disorders (DSM-5-TR)*.

11. National Institute of Mental Health. (2024). *Eating disorders*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/eating-disorders>

DSM-5 Criteria for Anorexia Nervosa¹²

- Restriction of energy intake relative to requirements, leading to significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as weight less than minimally normal, or in children and adolescents, less than that minimally expected.
- Intense fear of gaining weight or becoming fat or persistent behavior that interferes with weight gain, even though already at a significantly low weight.
- Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

The type is specified as follows:

- **Restricting type:** Weight loss is accomplished primarily through dieting, fasting, or excessive exercise. During the last three months, the individual has not engaged in recurrent episodes of binge eating or purging behavior.
- **Binge eating/purging type:** During the last three months, the individual has engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

12. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

Bulimia Nervosa

Bulimia nervosa is a condition where people have recurrent and frequent episodes of binge eating (i.e., eating unusually large amounts of food in a short amount of time while also feeling a lack of control over these episodes). Binge eating is followed by behaviors used to eliminate the excess food such as forced vomiting, excessive use of laxatives or diuretics, fasting, excessive exercise, or a combination of these behaviors. People with bulimia nervosa may be slightly underweight, normal weight, or overweight.¹³ Clients with combination Anorexia Nervosa-Bulimia Nervosa have a significantly low body weight, whereas clients with Bulimia Nervosa typically have a normal or above-normal body weight. Unlike anorexia nervosa, bulimia nervosa can be harder to detect, as individuals may fall anywhere along the weight spectrum.

Signs and symptoms of bulimia nervosa include the following¹⁴:

- Chronically inflamed and sore throat
- Swollen salivary glands in the neck and jaw area
- Worn tooth enamel and increasingly sensitive and decaying teeth as a result of exposure to stomach acid
- Acid reflux disorder and other gastrointestinal problems
- Intestinal distress and irritation from laxative abuse
- Severe dehydration from purging of fluids
- Disruptions in sodium, calcium, potassium, and other minerals, increasing the risk of dysrhythmias and cardiac arrest

13. National Institute of Mental Health. (2024). *Eating disorders*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/eating-disorders>

14. National Institute of Mental Health. (2024). *Eating disorders*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/eating-disorders>

See the following box for *DSM-5-TR* criteria for diagnosing bulimia nervosa.

DSM-5-TR Criteria for Bulimia Nervosa¹⁵

- Recurrent episodes of binge eating. A binge eating episode is characterized by both of the following:
 - Eating in a discrete period of time (e.g., within any two-hour period) an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.
 - A sense of lack of control overeating during the episode (i.e., feeling that one cannot stop eating or control what or how much one is eating).
- Recurrent inappropriate compensatory behavior to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.
- The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for three months.
- Self-evaluation is unduly influenced by body shape and weight.
- The disturbance does not occur exclusively during episodes of anorexia nervosa.

15. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

Binge Eating Disorder

Binge eating disorder is the most common eating disorder in the United States.¹⁶ **Binge eating disorder** is a condition where people lose control over their eating and have recurring episodes of eating unusually large amounts of food. However, unlike bulimia nervosa, periods of binge eating are not followed by purging, excessive exercise, or fasting. As a result, people with binge eating disorder often are overweight or obese.¹⁷

These are the signs and symptoms of a binge eating disorder¹⁸:

- Eating unusually large amounts of food in a specific amount of time, such as a two-hour period
- Eating even when feeling full or not hungry
- Eating at a fast pace
- Eating until uncomfortably full
- Eating alone or in secret to avoid embarrassment
- Feeling distressed, ashamed, or guilty about eating
- Frequent dieting, possibly without weight loss

See the *DSM-5-TR* criteria for diagnosing binge eating disorder in the following box.

16. National Institute of Mental Health. (2024). *Eating disorders*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/eating-disorders>

17. National Institute of Mental Health. (2024). *Eating disorders*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/eating-disorders>

18. National Institute of Mental Health. (2024). *Eating disorders*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/eating-disorders>

DSM-5-TR Criteria for Binge Eating Disorder¹⁹

- Recurrent episodes of binge eating. An episode of binge eating includes eating within any 2-hour period) an amount of food that is definitely larger than what most people would eat in a similar amount of time under similar circumstances, and a sense of lack of control over eating during the episode.
- The binge eating episodes are associated with three (or more) of the following:
 - Eating much more rapidly than normal.
 - Eating until feeling uncomfortably full.
 - Eating large amounts of food when not feeling physically hungry.
 - Eating alone because of being embarrassed by how much one is eating.
 - Feeling disgusted with oneself, depressed, or very guilty afterward.
- Marked distress regarding binge eating is present.
- The binge eating occurs, on average, at least once a week for three months.
- The binge eating is not associated with the recurrent use of inappropriate compensatory behavior, such as in bulimia nervosa, and does not occur exclusively during the course

¹⁹. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

of bulimia nervosa or anorexia nervosa.

Other Eating Disorders

Pica is another type of eating disorder in which an individual repeatedly eats things that are not considered food and have no nutritional value, such as paper, dirt, soap, hair, glue, or chalk. Individuals with pica do not usually have an aversion to food, and ingested items vary with age. The behavior is inappropriate to the developmental level of the individual and is not part of a culturally supported practice. A person diagnosed with pica is at risk for potential intestinal blockages or toxic effects of substances consumed (such as lead in paint chips). Treatment for pica involves testing for nutritional deficiencies and addressing them if needed. Behavioral interventions used to treat pica may include redirecting the individual from the nonfood items and rewarding them for setting aside or avoiding nonfood items.²⁰

While pica is most commonly seen in children, it also occurs in individuals with intellectual disabilities and, in some cases, during pregnancy.

Diagnosis, according to the DSM-5-TR is based on the following criteria²¹:

- Persistent eating of non-nutritive, nonfood substances for at least one month

20. American Psychiatric Association. (2023). *What are eating disorders?* <https://www.psychiatry.org/patients-families/eating-disorders/what-are-eating-disorders>

21. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

- The eating of these substances is inappropriate for the individual's developmental level
- The eating behavior is not part of culturally supported or socially normative practice

Health risks associated with pica depend on the type of substance ingested:

- **Geophagia** (Clay Eating): Can lead to constipation, hypokalemia, nutritional deficiencies, and exposure to infectious agents like parasites. Clay contaminated with lead increases the risk of lead poisoning.
- **Pagophagia** (Ice Eating): Associated with iron deficiency, particularly during pregnancy, can lead to tooth decay and sensitivity.
- **Amylophagia** (Starch Eating): Also linked to iron deficiency, and in excessive amounts, may contribute to high blood sugar and obesity due to its carbohydrate content.
- **Toxic Substances:** Some nonfood items contain harmful contaminants such as lead, mercury, arsenic, and fluoride, which can cause poisoning, neurological damage, or organ dysfunction.

Pica during pregnancy can have severe consequences for both the mother and fetus. Lead exposure from pica has been linked to long-term neurological disabilities in children, and maternal geophagy has been associated with childhood motor function delays.

The cause of pica remains unknown. However, several factors may contribute to its development, including:

- Stress
- Cultural influences
- Learned behavior
- Low socioeconomic status
- Underlying mental health disorders
- Nutritional deficiencies
- Child neglect
- Pregnancy

- Epilepsy
- Familial psychopathology

Treatment and Management for pica involves testing and addressing any underlying nutritional deficiencies, particularly iron and zinc. Behavioral interventions, such as redirecting individuals from nonfood items and reinforcing appropriate eating behaviors, are commonly used. In cases where pica coexists with other mental health conditions, treatment may involve therapy or medications to manage underlying psychiatric symptoms²².

Avoidant restrictive food intake disorder (ARFID) is a condition where individuals limit the amount or type of food eaten. Unlike anorexia nervosa, people with ARFID do not have a distorted body image or extreme fear of gaining weight. ARFID is most common in middle childhood and usually has an earlier onset than other eating disorders. Many children go through phases of picky eating, but a child with ARFID does not eat enough calories to grow and develop properly, and an adult with ARFID does not eat enough calories to maintain basic body function.²³

Signs and symptoms of ARFID include the following²⁴:

- Dramatic restriction of types or amount of food eaten
- Lack of appetite or interest in food

22. Al Nasser, Y., Muco, E., & Alsaad, A. J. (2025). *Pica*. StatPearls [Internet]. <https://www.ncbi.nlm.nih.gov/books/NBK532242/>

23. National Institute of Mental Health. (2024). *Eating disorders*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/eating-disorders>

24. National Institute of Mental Health. (2024). *Eating disorders*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/eating-disorders>

- Dramatic weight loss
- Upset stomach, abdominal pain, or other gastrointestinal issues with no other known cause
- Limited range of preferred foods that becomes even more limited (i.e., “picky eating” that gets progressively worse)

ARFID does not include food restriction related to lack of availability of food; dieting; cultural practices, such as religious fasting; or developmentally normal behaviors, such as toddlers who are picky eaters. Food avoidance or restriction commonly develops in infancy or early childhood and may continue in adulthood, but it can start at any age. Regardless of the age of the person affected, ARFID can impact families, causing increased stress at mealtimes and in other social eating situations. Treatment for ARFID involves an individualized plan and may involve several specialists, including a mental health professional and a registered dietitian.

Body Mass Index

Body mass index (BMI) is a person’s weight in kilograms divided by the square of height in meters. BMI is an easy screening method to determine if an individual’s weight is classified as underweight, healthy weight, overweight, or obese. However, it is important to remember that BMI is a screening method and does not take into account muscle mass, bone density, overall body composition, racial, and sex differences.²⁵ See Table 13.2a for adult weight status according to BMI ranges.

Table 13.2a Adult Weight Status by BMI²⁶

25. Nordqvist, C. (2022). *Why BMI is inaccurate and misleading*. Medical News Today. <https://www.medicalnewstoday.com/articles/265215>

26. Centers for Disease Control and Prevention. (2024). *Adult BMI calculator*. <https://www.cdc.gov/bmi/adult-calculator/>

BMI	Weight Status
Below 18.5	Underweight
18.5 – 24.9	Healthy Weight
25.0 – 29.9	Overweight
30.0 or higher	Obese

For children and teens, the interpretation of BMI depends upon their age and sex. After BMI is calculated for children and teens, it is expressed as a percentile obtained from either a percentile calculator or growth chart. See categories of weight status based on BMI percentiles in Table 13.2b. Links to calculators and growth charts are provided in the following box.

Table 13.2b Child or Adolescent Weight Status by BMI Percentile²⁷

BMI Percentile	Weight Status
Less than 5th Percentile	Underweight
5th Percentile to Less Than 85th Percentile	Healthy Weight
85th Percentile to Less Than 95th Percentile	Overweight
95th Percentile or Higher	Obese

Calculating BMI

- ▶ The CDC’s Adult [BMI Calculator](https://www.cdc.gov/bmi/child-teen-calculator/) conveniently calculates a

27. Centers for Disease Control and Prevention. (2024). *Child and teen BMI calculator*. <https://www.cdc.gov/bmi/child-teen-calculator/>

- ▶ person's BMI based on their height and weight. The following formulas can also be used to calculate a person's BMI²⁸:
 - $\text{weight (kg)} / [\text{height (m)}]^2$ or
 - $\text{weight (lb)} / [\text{height (in)}]^2 \times 703$
- ▶ The CDC's [BMI Percentile Calculator for Children and Adolescents](#) conveniently calculates a child's or adolescent's BMI percentile based on their height, weight, gender, and age. Otherwise, gender growth charts are used to determine BMI percentiles and then their weight status is determined using the appropriate table below:
 - [CDC extended BMI-for-age growth charts](#)

Risk Factors

The exact cause of eating disorders is not fully understood, but research suggests that a combination of genetic, biological, behavioral, psychological, and cultural factors can increase a person's risk. Eating disorders are hereditary. Researchers are working to identify DNA variations that are linked to the increased risk of developing eating disorders. Brain imaging studies are also providing a better understanding of eating disorders. For example, researchers have found differences in patterns of brain activity in women with eating disorders in comparison to healthy women. This kind of research can help guide the development of new means of diagnosis and treatment of eating disorders.²⁹

28. Nordqvist, C. (2022). *Why BMI is inaccurate and misleading*. Medical News Today. <https://www.medicalnewstoday.com/articles/265215>

29. National Institute of Mental Health. (2024). *Eating disorders*. U.S. Department

Although genetics increases the risk for developing eating disorders, the individual's environment plays a significant role. Onset can occur at nearly any point in the life span, but eating disorders commonly start in adolescence and young adulthood when there can be exceptional pressure from peers, social media, advertisements, etc., to diet or lose weight. For those genetically vulnerable to eating disorders, initial weight loss may reinforce a reward feedback mechanism and establish a maladaptive eating behavior pattern. Physiological and sensorial changes result in alterations in hunger and satiety, gastrointestinal motility, and decision-making around food and eating.

As you consider the genetic, environmental, and social influences of eating disorders, recognize that a combination of these factors can affect the severity and presenting characteristics for each client. Additionally, although eating disorders are commonly thought of as affecting young women, it can affect people of all genders, ages, races/ethnicities, body weights, and socioeconomic statuses. See Figure 13.3³⁰ for an illustration of its diverse impact. Some individuals are mildly affected throughout their lives but then triggered by a significant physical or emotional life event that manifests clinical worsening.

of Health and Human Services. <https://www.nimh.nih.gov/health/topics/eating-disorders>

30. [“eating-disorders-everyone-sm.jpg”](#) by U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health is in the [Public Domain](#)



Figure 13.3 Eating Disorders Affect Anyone

Cultural Considerations

Cultural beliefs impact self-concept and satisfaction with body size. Anorexia nervosa is associated with cultures that value thinness. When caring for a client with an eating disorder, cultural considerations need to be addressed to ensure effective and culturally sensitive care. For example, Western cultures often emphasize thinness, which can contribute to body dissatisfaction and eating disorders. Furthermore, studies indicate that social media significantly influences these beliefs. For example, one study found that participants with higher use of social media had significantly greater odds of having eating concerns.³¹ See Figure 13.4³² for an image of an extremely underweight fashion model in a culture that values thinness.

31. Sidani, J. E., Shensa, A., Hoffman, B., Hanmer, J., & Primack, B. A. (2016). The association between social media use and eating concerns among us young adults. *Journal of the Academy of Nutrition and Dietetics*, 116(8), 1465-1472. <https://doi.org/10.1016/j.jand.2016.03.021>

32. “7991065935_8f05b38f46_k” by Farrukh is licensed under CC BY-NC 2.0.



Figure 13.4 Underweight model

Black and Hispanic teenagers are more likely to suffer from bulimia nervosa. Additional considerations are the influences of some sports cultures on athletes where weight is a consideration, such as in wrestling, gymnastics, figure skating, and body building.³³ Nurses should be culturally competent and aware of the specific cultural context of their clients. This includes understanding cultural norms, values, and potential barriers to treatment.

View a supplementary YouTube video³⁴ about eating disorders: [Eating Disorders: Psychiatric Mental Health for Nursing Students | @LevelUpRN](https://www.youtube.com/watch?v=IFBXsrSvIOI)

33. National Eating Disorders Association. (n.d.). *Statistics and research on eating disorders*. <https://www.nationaleatingdisorders.org/statistics-research-eating-disorders>

34. Level Up RN. (2023, September 11). *Eating disorders: psychiatric mental health for nursing students | @LevelUpRN* [Video]. Youtube. All rights reserved. <https://www.youtube.com/watch?v=IFBXsrSvIOI>

13.3 Treatment for Eating Disorders

Early treatment is important for individuals with eating disorders because of increased risk for suicide, self-injury behaviors, and medical complications. People with eating disorders may also have other mental health disorders (such as depression or anxiety) or problems with substance use. There are a variety of treatments that have been shown to be effective in treating eating disorders. Generally, treatment is more effective before the disorder becomes chronic, but even people with long-standing eating disorders can recover.¹ It is important to note that treatment can be difficult for some individuals to obtain due to limited options and scarce resources in many rural areas.

The choice of treatment depends on the specific type of eating disorder, the severity of the condition, and the individual's needs. Treatment plans may include one or more of the following:

- Individual, group, and/or family psychotherapy
- Medications
- Nutritional counseling
- Medical care and monitoring

Psychotherapy

Cognitive behavioral therapy (CBT) is used to reduce or eliminate binge eating and purging behaviors. Therapy focuses on modifying dysfunctional

1. National Institute of Mental Health. (2024). *Eating disorders*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/eating-disorders>

thoughts and behaviors related to eating, body image, and weight.² Limited provider availability may require individuals to complete therapy virtually.

Read more about CBT in the “[Treatments for Depression](#)” section of the “Depressive Disorders chapter.

Family-based therapy a type of psychotherapy in which parents take an active role in managing their child’s eating behaviors and weight restoration. This approach involves parents carefully monitoring all of the client’s eating and activities to prevent excessive exercise and purging. The goal is to promote healthy eating behaviors and weight restoration, with parents providing structure and support to reduce parental distress and anxiety. As treatment progresses, autonomy in feeding is gradually shifted back to the adolescent, and the focus shifts to improving family communication and independence. This therapy has been found to be very effective in helping adolescents gain weight and improve eating habits and moods.³

Interpersonal Psychotherapy (IPT): IPT is another effective treatment, focusing on improving interpersonal functioning and reducing eating disorder symptoms.

Medications

Evidence also suggests that medications such as antidepressants, antipsychotics, or mood stabilizers may also be helpful for treating eating

2. National Institute of Mental Health. (2024). *Eating disorders*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/eating-disorders>
3. National Institute of Mental Health. (2024). *Eating disorders*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/eating-disorders>

disorders and other co-occurring mental illnesses such as anxiety or depression.⁴ Fluoxetine, a selective serotonin reuptake inhibitor (SSRI), is FDA-approved for the treatment of bulimia nervosa (BN) and has demonstrated efficacy in reducing binge-purge behaviors. Lisdexamfetamine, approved for binge eating disorder (BED), effectively decreases the frequency of binge eating episodes. Although not FDA-approved for anorexia nervosa (AN), olanzapine has shown potential benefits by promoting weight gain and alleviating anxiety symptoms in individuals with AN.⁵

- ▶ Read more about antidepressants in the “[Treatments for Depression](#)” section of the “Depressive Disorders” chapter.
- ▶ Read more about antipsychotics in the “[Schizophrenia](#)” section of the “Psychosis and Schizophrenia” chapter.

Nutritional Rehabilitation & Counseling

Nutritional rehabilitation is essential for all eating disorders, nutritional rehabilitation aims to restore healthy eating patterns and address malnutrition. Registered dietitian nutritionists play a crucial role in this aspect of treatment. Nutritional counseling by a dietician with specialized training is necessary for individuals with eating disorders. The counseling should

4. National Institute of Mental Health. (2024). *Eating disorders*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/eating-disorders>
5. Muratore, A. F., & Attia, E. (2022). Psychopharmacologic management of eating disorders. *Current Psychiatry Reports*, 24(7), 345-351. doi: [10.1007/s11920-022-01340-5](https://doi.org/10.1007/s11920-022-01340-5).

incorporate education about nutritional needs, as well as planning and monitoring healthy food choices.⁶

Medical Care and Monitoring

Medical treatments for eating disorders can be delivered in a variety of settings and are guided by the severity and chronicity of the illness, medical stability, insurance coverage, and available community resources. The following characteristics apply to the setting selected for an individual's treatment⁷:

- **Outpatient Treatment:** This is suitable for clients who are medically stable and can maintain their daily activities. It includes regular visits to a healthcare team comprising a physician, therapist, and dietitian.
- **Intensive Outpatient:** The client is medically and psychiatrically stable and does not need daily medical monitoring. Symptoms are under sufficient control for the individual to be able to function in normal social, educational, or vocational situations and continue to make progress in recovery.
- **Partial Hospitalization:**
 - The client is medically stable. The eating disorder impairs functioning but is without immediate risk. The client requires daily assessment of physiologic and mental status.
 - The client is psychiatrically stable but is unable to function in normal social, educational, or vocational situations. They engage in daily binge eating, purging, fasting, restricted food intake, or other pathogenic weight control techniques.

6. National Eating Disorders Association. (n.d.). *Treatment*.
<https://www.nationaleatingdisorders.org/treatment>

7. National Eating Disorders Association. (n.d.). *Treatment*.
<https://www.nationaleatingdisorders.org/treatment>

- **Residential:** The client is medically stable and requires no intensive medical intervention. They are psychiatrically impaired and unable to respond to partial hospital or outpatient treatment.
- **Inpatient:**
 - The client is medically unstable as determined by:
 - Unstable or depressed vital signs
 - Laboratory findings presenting acute health risk
 - Complications due to coexisting medical problems such as diabetes
 - The client is psychiatrically unstable as determined by:
 - Rapidly worsening symptoms
 - Suicidal ideation with a plan and unable to contract for safety

13.4 Applying the Nursing Process to Eating Disorders

People with eating disorders may appear healthy even when they are very ill. Additionally, individuals with anorexia nervosa often do not view their behavior as a problem. They are typically only seen in health care settings due to concerned family or friends who encourage them to seek treatment. Conversely, individuals with bulimia nervosa or binge eating disorder may feel shame and sensitivity to the perceptions of others regarding their illness. Therefore, it is vital for the nurse to build a therapeutic nurse-client relationship with clients with eating disorders and empathize with possible feelings of low self-esteem and lack of control over eating.¹

This section will apply the nursing process to anorexia and bulimia nervosa.

Assessment (Recognizing Cues)

When assessing an individual with a potential or diagnosed eating disorder, it is vital to obtain their perception of the problem while assessing for signs and symptoms. Care planning that does not address their perspective will not be effective. As previously mentioned, clients with anorexia nervosa often do not perceive their behaviors as a problem, so specialized therapeutic techniques are required. Review signs and symptoms associated with various eating disorders in the “[Basic Concepts](#)” section.

A complete nursing assessment includes mental status examination, psychosocial assessment, and screening for risk of suicide or self-harm. Nutritional patterns, fluid intake, and daily exercise should also be assessed. If the client has a bingeing or purging pattern, the amount of food eaten and/or the frequency of these behaviors should be assessed.

1. Halter, M. (2022). *Varc Carolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

Mental Status Examination

See Table 13.4a for common findings when assessing a client with an eating disorder. (See expected findings for these components of a mental status examination in the “[Assessment](#)” section in Chapter 4.) Critical findings that require immediate notification of the provider are bolded with an asterisk.

Table 13.4a Common Findings During Mental Status Examinations for Clients With Eating Disorders²

2. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

Mental Status Examination Component	Common Findings in Eating Disorders (*Indicates immediately notify provider)
Signs of Distress	May appear anxious, preoccupied with food, weight, or body image; may exhibit shame, denial, or resistance when discussing eating behaviors. Clients with bulimia may appear more outwardly distressed or dysregulated; those with anorexia may appear emotionally blunted.
Level of Consciousness and Orientation	Typically alert and oriented unless severely malnourished, in which case confusion, poor concentration, or delayed responses may occur.
Appearance and General Behavior	May appear underweight (anorexia), within normal weight range (bulimia), or overweight (binge eating disorder). Common findings: baggy clothing to hide body shape, pale or dry skin, lanugo (fine body hair), brittle hair/nails, signs of vomiting (e.g., Russell's sign, dental erosion). Behavior may be avoidant or perfectionistic.
Speech	Generally normal in rate and volume, but may be guarded or evasive about food-related topics. Some clients may exhibit pressured speech if anxious; others may appear overly controlled.
Motor Activity	May be restless or hyperactive (common in anorexia), or sluggish due to malnutrition. Repetitive or ritualistic movements (e.g., fidgeting, checking body parts) may be observed.
Mood and Affect	Mood is often anxious, irritable, or depressed. Affect may be blunted or restricted, especially in anorexia. Clients may express low self-worth or describe feelings of shame, guilt, or emptiness.

Thought and Perception	Thought content often centers on body image distortion, weight obsession, and fear of gaining weight. Clients may express rigid thinking patterns or perfectionism. *Suicidal ideation may be present in severe cases or with coexisting depression.
Attitude and Insight	Often demonstrate poor insight into the severity of the disorder. Clients may deny being underweight or minimize behaviors such as purging or restricting. May resist treatment, particularly if weight restoration is a goal.
Cognitive Abilities and Level of Judgment	Memory and attention typically intact unless severely malnourished. Clients may exhibit obsessive thoughts, poor concentration, and rigid cognitive patterns. Judgment and decision-making may be impaired by body image distortions.

Psychosocial Assessment

As previously discussed in the “[Application of the Nursing Process in Mental Health Care](#)” chapter, a psychosocial assessment obtains additional subjective data that detects risks and identifies treatment opportunities and resources.³⁴

- Reason for seeking health care (i.e., “chief complaint”)
- Thoughts of self-harm or suicide (both current and historical)

3. Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder. (2017). *What is cognitive behavioral treatment?* American Psychological Association. <https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral>
4. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

- Cultural assessment
- Spiritual assessment
- Family dynamics
- Current and past medical history
- Current medications
- History of previously diagnosed mental health disorders
- Previous hospitalizations
- Educational background
- Occupational background
- History of exposure to psychological trauma, violence, and domestic abuse
- Substance use (tobacco, alcohol, recreational drugs, misused prescription drugs)
- Family history of mental illness
- Coping mechanisms
- Functional ability/Activities of daily living

After identifying the reason the client is seeking health care, additional focused questions are used to obtain detailed information used to plan care. The mnemonic PQRSTU can be used to ask questions in an organized fashion. See Table 13.4b for a sample PQRST assessment for eating disorders and sample responses by a client.

Table 13.4b Sample PQRSTU Questions for Assessing Eating Disorders

PQRSTU	Sample Questions	Sample Client Response
Provocation/ Palliation	“What seems to trigger your eating behaviors or concerns about food or your body?” “What helps you cope or feel better?”	“It usually starts when I feel stressed or out of control. Looking at myself in the mirror makes it worse. Skipping meals helps me feel like I’m in control again.”
Quality	“Can you describe the thoughts or feelings you have about food or your body?”	“I constantly think about calories and weight. Even when I eat something small, I feel guilty and disgusting. It feels like I’m never thin enough.”
Region	“Do you feel any physical effects from your eating behaviors—like pain, fatigue, or other sensations?”	“I’m always cold and tired. Sometimes I get dizzy when I stand up too fast. My stomach hurts, but I don’t really feel hungry anymore.”
Severity	“How much does this affect your daily life?”	I think about food and my body all day. It’s hard to focus on school or even talk to my friends.”
Timing/ Treatment	“When did these behaviors or thoughts start? How often do they happen?”	“It started around two years ago, but got worse this past year. I am very careful about what I eat most days, but sometimes I binge and then purge at night.”
Understanding	“What do you believe is causing this? How do you understand what you’re going through?”	“When my life feels overwhelming, I focus on food and weight because it’s the one thing I can manage successfully.”

SUICIDE AND SELF INJURY SCREENING

Clients being evaluated or treated for eating disorders often have suicidal

ideation, especially if they are also experiencing a depressive disorder. The Patient Safety Screener (PSS-3) is an example of a brief screening tool to detect suicide risk in all client presenting to acute care settings.⁵

Non-suicidal self-injury (NSSI) refers to intentional self-inflicted destruction of body tissue without suicidal intention and for purposes not socially sanctioned. Common forms of NSSI include behaviors such as cutting, burning, scratching, and self-hitting. It is considered a maladaptive coping strategy without the desire to die. NSSI is a common finding among adolescents and young adults in psychiatric inpatient settings.⁶

Review information about suicide screening, the Patient Safety Screener, and screening for non-suicidal self-injury (NSSI) in the “[Assessment](#)” section of the *Applying the Nursing Process to Mental Health Care* chapter.

CULTURAL ASSESSMENT

Cultural Formulation Interview (CFI) questions help nurses understand a client’s cultural background and how it influences their experience of eating disorders.⁷ Sample CFI questions focused specifically on understanding eating disorders within a cultural context include the following:

5. Suicide Prevention Resource Center. (n.d.). *The patient safety screener: A brief tool to detect suicide risk*. <https://sprc.org/micro-learning/patientsafetyscreener>
6. Cipriano, A., Cella, S., & Cotrufo, P. (2017). Nonsuicidal self-injury: A systematic review. *Frontiers in Psychology*, 8. <https://www.frontiersin.org/articles/10.3389/fpsyg.2017.01946/full>
7. DeSilva, R., Aggarwall, N. K., & Lewis-Fernandez, R. (2015). The DSM-5 cultural formulation interview and the evolution of cultural assessment in psychiatry. *Psychiatric Times*, 32(6). <https://www.psychiatrictimes.com/view/dsm-5-cultural-formulation-interview-and-evolution-cultural-assessment-psychiatry>

- Cultural Definition of the Problem
 - “How would you describe the difficulties you’re having with eating, food, or your body?”
 - “Are there any words or used in your community or family to describe what you’re going through?”
- Cultural Perceptions of Cause, Context, and Support
 - “What do you think is causing these problems with eating or your body image?”
 - “Are there cultural or family expectations around food, weight, or appearance that you think affect you?”
 - “How do your family and friends view your eating habits? Do they express concerns about your weight?”
 - “Do you feel any pressure from your friends to look or eat a certain way?”
- Cultural Factors Affecting Coping and Help-Seeking
 - “What kinds of things have you done to cope with these feelings so far?”
 - “Are there any traditional remedies, rituals, or religious practices you use to feel better?”
 - “Have you tried to talk to anyone about these feelings, like family members, friends, religious leaders, or traditional healers?”
 - “Do people in your community seek help for issues with food or body image? If so, from whom?”
- Cultural Features of the Nurse–Client Relationship
 - ““Is there anything I should know about your background or beliefs that would help me better understand you?”
 - “Do you have any concerns or hesitations you have about seeing a mental health professional?”
 - “What kind of help do you think would work best for you?”

Findings from the cultural formulation interview are used to individualize a client’s plan of care to their preferences, values, beliefs, and goals.

Objective Assessment

Common objective assessment findings for individuals with anorexia nervosa and bulimia nervosa are compared in Table 13.4c. Note that clients with binge eating disorder may have obesity and gastrointestinal symptoms but do not typically have other associated abnormal assessment findings.

Table 13.4c Comparison of Assessment Findings in Anorexia Nervosa and Bulimia Nervosa⁸

8. Halter, M. (2022). *Varc Carolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

Anorexia Nervosa	Bulimia Nervosa
Low weight	Normal to slightly low weight
Muscle weakening (from starvation and electrolyte imbalance)	Muscle weakening (from electrolyte imbalance)
Peripheral edema (from hypoalbuminemia)	Peripheral edema (from rebound fluids if diuretics are used)
Cardiovascular abnormalities (hypotension, bradycardia, heart failure from starvation, and dehydration)	Cardiovascular abnormalities (cardiomyopathy and cardiac dysrhythmias from electrolyte imbalances)
Abnormal lab results (hypokalemia and anemia from starvation)	Electrolyte imbalances (hypokalemia and hyponatremia from diuretics, laxatives, or vomiting)
Other signs: Amenorrhea (lack of menstruation) Lanugo (growth of fine hair all over the body) Cold extremities Constipation Impaired renal function Decreased bone density Wearing many layers of clothing due to feeling cold and also to hide body frame.	Other signs: Tooth erosion or dental caries (from vomiting reflux over enamel) Parotid swelling (due to increased serum amylase levels) Calluses or scars on hand (from self-induced vomiting) Seizures (purging via self-induced vomiting lowers seizure threshold)

Diagnostic and Lab Work

Laboratory and diagnostic testing are typically performed to rule out thyroid imbalances and to evaluate for potential physiological complications resulting

from starvation, dehydration, and electrolyte imbalances. Laboratory testing may include the following⁹:

- Complete blood count
- Electrolyte levels
- Glucose level
- Thyroid function tests
- Erythrocyte sedimentation rate (ESR)
- Creatine phosphokinase (CPK)

Diagnostic testing may include these tests:

- Electrocardiogram (ECG)
- Dual energy X-ray absorptiometry (DEXA) to measure bone density

Lifespan Considerations

Life span considerations influence how the client is assessed, as well as the selection of appropriate nursing interventions. It is important to individualize all interventions to the age and developmental level of the client. Review developmental stages in the “[Application of the Nursing Process in Mental Health Care](#)” chapter.

CHILDREN AND ADOLESCENTS

Eating disorders (EDs) are often underdiagnosed and many adolescents go untreated, do not recover, or only reach partial recovery. Denial of symptoms is common. Higher rates of EDs are being seen in younger children, boys, and in minority groups. EDs are also being increasingly recognized in clients with obesity. Family influence must be considered. Individual treatment including

9. Halter, M. (2022). *Varc Carolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

cognitive behavioral therapy and family-based treatment focused on weight restoration and reducing blame can be effective.¹⁰

OLDER ADULTS

Older adults may present with unintentional weight loss, disinterest in food, or somatic complaints. Their focus may be on control rather than weight or body image. Symptoms may be misattributed to aging, other medical conditions, dementia, or side effects of medications. Perceived stigma may prevent older adults from discussing eating habits, body image concerns, or feelings. Grief, isolation, depression, and anxiety may increase risk for eating disorders.¹¹

Diagnosis (Analyzing Cues)

Common nursing diagnoses for individuals diagnosed with anorexia nervosa or bulimia nervosa include these diagnoses¹²:

- Imbalanced Nutrition: Less Than Body Requirements
- Imbalanced Nutrition: More Than Body Requirements
- Risk for Electrolyte Imbalance
- Risk for Imbalanced Fluid Volume
- Impaired Body Image

10. Campbell, K., & Peebles, R. (2014). Eating disorders in children and adolescents: State of the art review. *Pediatrics*, 134(3), 582–592. <https://doi.org/10.1542/peds.2014-0194>

11. Lapid, M. I., Prom, M. C., Burton, M. C., et al. (2010). *Eating disorders in the elderly*. *International Psychogeriatrics*, 22(4), 523–536, <https://doi.org/10.1017/S1041610210000104>

12. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

- Ineffective Coping
- Interrupted Family Processes
- Chronic Low Self-Esteem
- Powerlessness
- Risk for Spiritual Distress

Outcome Identification (Generate Solutions)

Outcomes are individualized to client's situation and diagnosis and symptoms and should address the acute nursing diagnosis with prioritization on safety. These are the typical overall treatment goals for individuals with eating disorders¹³:

- Restoring adequate nutrition
- Bringing weight to a healthy level
- Reducing excessive exercise
- Stopping binge-purge and binge eating behaviors

SMART expected outcomes are individualized for each client based on their established nursing diagnoses and current status. (SMART is an acronym for Specific, Measurable, Attainable/Actionable, Relevant, and Timely.) Examples of SMART outcomes for an individual hospitalized with anorexia nervosa who is experiencing electrolyte imbalances are:

- *The client will maintain a normal sinus heart rhythm with a regular rate during their hospitalization.*
- *"The client will achieve and maintain normal electrolyte levels (potassium, sodium, magnesium, and phosphorus) within the reference range, as measured by daily blood tests, for at least 7 consecutive days before discharge, through adherence to the prescribed nutritional plan*

13. National Institute of Mental Health. (2024). *Eating disorders*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/eating-disorders>

and medical interventions.”

Planning (Generate Solutions)

Safety

Safety receives top priority when planning and implementing interventions for clients with eating disorders who are at risk of suicide. If the client is exhibiting risk for suicide, a safety plan should be immediately implemented. Review nursing care for clients with risk for suicide in the “[Application of the Nursing Process in Mental Health Care](#)” chapter.

Planning other interventions depends on the acuity of the client’s clinical status and their established expected outcomes. As previously discussed, clients are hospitalized for stabilization. Common criteria for hospitalization include extreme electrolyte imbalance, weight below 75% of healthy body weight, arrhythmias, hypotension, temperature less than 98 degrees Fahrenheit, or risk for suicide.¹⁴ After a client is medically stable, the treatment plan includes a combination of psychotherapy, medications, and nutritional counseling. Review the “[Treatment for Eating Disorders](#)” section for more details.

Implementation (Take Action)

Inpatient Care

Severely malnourished clients may require therapeutic enteral nutrition. Any client with negligible food intake for more than five days is at risk of developing a potentially fatal complication called **refeeding syndrome**. The hallmark feature of refeeding syndrome is hypophosphatemia but may also involve serious sodium and fluid imbalances; changes in glucose, protein, and

14. Halter, M. (2022). *Varc Carolis’ foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

fat metabolism; thiamine deficiency; hypokalemia; and hypomagnesaemia. To avoid this syndrome, a thorough nutritional assessment must be performed followed by the slow reintroduction of nutrients and fluids according to evidence-based guidelines.¹⁵

After resolving acute symptoms, clients with anorexia nervosa begin a weight restoration program for incremental weight gain with a treatment goal set for 90% of ideal body weight. Specially trained dietitians assist in developing daily meal plans and caloric intake, and clients are generally weighed two or three times a week to gauge progress.¹⁶

Nurses should be aware that clients with bulimia nervosa typically establish a therapeutic nurse-client relationship more quickly than clients with anorexia nervosa. As previously discussed in this chapter, clients with anorexia nervosa often do not view their condition as a disorder and value their obsessive-compulsive behaviors with eating as a way to feel safe and secure and avoid negative feelings. Conversely, clients with bulimia nervosa view their behaviors as problematic and desire help.¹⁷

Outpatient Care

Outpatient partial hospitalization is an option for clients who have been medically stabilized. In this setting, clients are in a clinical setting during the day and then go home to practice skills in the afternoon. Outpatient

15. Mehanna, H. M., Moledina, J., & Travis, J. (2008). Refeeding syndrome: What it is, and how to prevent and treat it. *BMJ*, 336, 1495–1498. <https://doi.org/10.1136/bmj.a301>
16. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.
17. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

treatment continues if the client maintains a contracted weight, vital signs are within a normal range, and there is an absence of disordered eating behaviors.¹⁸

A significant part of the recovery process includes rebuilding relationships with family. Family members or significant others often feel frustrated, powerless, and hopeless. Family members may feel overwhelmed and exhausted at the level of care and monitoring required to support the client with an eating disorder into recovery because the strategies they previously attempted, such as forcing the client to eat or begging the client to eat, were not successful. The nurse helps with this recovery process by providing education to the client and their loved ones about the illness, treatment, and meal planning. Adaptive coping skills to address disordered thoughts should be reinforced.¹⁹ Review information about coping strategies in the “[Stress, Coping, and Crisis Intervention](#)” chapter.

Nursing Interventions for Eating Disorders Based on Categories of the APNA Implementation Standard

Nurses individualize interventions based on the client’s current clinical status and their phase of treatment. Interventions can be categorized based on the American Psychiatric Nursing Association (APNA) standard for *Implementation* that includes the *Coordination of Care; Health Teaching and Health Promotion; Pharmacological, Biological, and Integrative Therapies; Milieu Therapy; and Therapeutic Relationship and Counseling*. (Review information about these subcategories in the “[Application of the Nursing](#)

18. Halter, M. (2022). *Varcarolis’ foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

19. Halter, M. (2022). *Varcarolis’ foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

Process in Mental Health Care” chapter.) Read nursing interventions for clients with eating disorders categorized by APNA categories in Table 13.4d.

Table 13.4d Examples of Nursing Interventions for Clients with Eating Disorders by APNA Subcategories^{20, 21}

20. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.
21. American Nurses Association, American Psychiatric Nurses Association, and International Society of Psychiatric-Mental Health Nurses. (2014). *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* (2nd ed.).

Subcategory of the APNA Standard of Implementation	The nurse will ...	Rationale
Coordination of Care	• Communicate client trends with interprofessional team members, such as risk for suicide and target weight. A target weight and daily caloric intake are set in collaboration with the dietitian and the provider. • Collaborate with interdisciplinary team (physician, dietitian, therapist, social worker) to create a personalized care plan. Include family members when appropriate. • Refer to community resources and outpatient treatment.	Eating disorders require multidisciplinary management to address medical, psychological, and nutritional needs. Involving the family supports continuity and adherence.

Health Teaching and Health Promotion	• Provide education about the physical and psychological effects of eating disorders. • Teach about nutrition, body image, and coping strategies using age-appropriate language. Address myths about weight, food, and health.-Promote health by teaching adaptive coping strategies such as journaling. Support basic skills such as learning how to create meal plans, shopping at the grocery store, and navigating family or social eating situations.	Education increases insight, empowers recovery, and reduces maladaptive beliefs. Promoting healthy lifestyle choices supports long-term change. Nurses encourage resilience by promoting healthy coping strategies, communication, and problem-solving skills.

Pharmacological, Biological, and Integrative Therapies	• Deliver client education about antidepressants or other prescribed medications with expected time frames for improvement. • Monitor for side effects and signs of malnutrition (e.g., bradycardia, electrolyte imbalance). • Incorporate mindfulness, journaling, or guided imagery to reduce anxiety.	Medications may help with comorbid anxiety or depression. Integrative therapies enhance self-regulation and reduce relapse risk. Medical monitoring ensures safety during nutritional rehabilitation.

Milieu Therapy	• Create a structured, nonjudgmental environment with consistent meal and weigh-in routines. • Establish therapeutic norms for group therapy and communal eating. • Monitor for food hoarding, purging, or excessive exercise.-Provide a pleasant, calm atmosphere at mealtimes. Emphasize the social nature of eating. Encourage conversations during mealtimes that do not involve the topics of eating or exercise.-Observe clients during meals to prevent hiding or throwing away food and at least one hour after eating to prevent purging.-Encourage the client to make their own menu choices as they	A therapeutic milieu provides predictability and safety, reduces secrecy, and supports behavioral stabilization. It also models healthy social interactions. The milieu of an eating disorder specialty unit is purposefully organized to assist the client in establishing healthy eating patterns and normalization of eating. The highly structured environment provides precise mealtimes, adherence to the meal plan, close observation of bathroom trips, and monitoring potential access to laxatives or diuretics. Mealtimes can cause episodes of high anxiety. The client should feel accepted and safe from judgmental evaluations in the milieu with a focus on eating behaviors and underlying feelings of anxiety, dysphoria, low self-esteem, and a lack of control.

	approach their goal weight.	

Therapeutic Relationship and Counseling	• Provide 1:1 therapeutic communication to encourage the client to develop adaptive coping strategies, use stress management techniques, develop supportive relationships, and seek spiritual resources. • Acknowledge the emotional and physical difficulty the client is experiencing. • Use motivational interviewing and contract with the client to increase their ownership of treatment goals. • Weigh the client daily in their underwear for the first week and then three times a week. Do not allow oral intake before the morning weigh-in. It is permissible for the client to not view the scale during the	Effective therapeutic techniques for clients with depression can promote hope and positive self-esteem. Clients with eating disorders often struggle with control and perfectionism; a supportive approach fosters motivation for recovery. The first priority is to establish a therapeutic relationship. A client's feelings of fatigue can be used to engage cooperation in the treatment plan. Motivational interviewing is a collaborative, goal-oriented style of communication. It is designed to strengthen personal motivation and commitment to specific goals by eliciting and exploring the person's reasons for change within an atmosphere of acceptance and compassion.²² Accurate weight taking and monitoring are vital. The client may try to control and sabotage the weight monitoring. The client is typically expected to gain 0.5 pound on a specific schedule. However, weight gain of more than five pounds in one week can cause pulmonary edema. The particulars of how clients should be weighed (i.e., open vs. blind weighed) is a point of debate in the field. Because viewing the scale can cause anxiety, blind weighing is typically used during the acute stage of treatment, whereas open weighing may be suitable at later stages of recovery.²³

22. Miller, W. R., & Rollnick, S. (2013). *Motivational Interviewing: Helping people to change* (3rd ed.). Guilford Press.
23. Foreich, F. V., Ratcliffe, S. E., & Vartanian, L. R. (2020). Blind versus open weighing from an eating disorder patient perspective. *Journal of Eating Disorders* 8, 39. <https://doi.org/10.1186/s40337-020-00316-1>

	weigh-in. • Administer liquid supplements as prescribed. • Be empathetic with the client's struggle to give up control of their eating and weight as they are expected to regain weight. Encourage the clients to verbalize or use a journal to record their feelings surrounding eating disorder behaviors. Confront irrational thoughts and beliefs to promote healthy eating behaviors. • Monitor physical activity and individualize the client's plans for exercise. • Focus on the client's strengths, including their work on normalizing weight and eating behaviors. Reinforce the knowledge and skills gained from	Oral or enteral supplements may be prescribed based on the client's status. However, be alert for refeeding syndrome in severely malnourished clients. External control is required initially to promote good nutrition and a healthy weight. Cognitive and behavioral changes will occur gradually. The client often experiences a strong drive to exercise. Nurses can assist in planning a reasonable amount of exercise. Acknowledge milestones and encourage other sources of gratification other than eating.

	individual, family, and group therapy sessions.	

Nursing Interventions for Physiological Signs of Eating Disorders

Nursing interventions also target common physiological signs of eating disorders as summarized in Table 13.4e.

Table 13.4e Nursing Interventions Targeting Physiological Signs of Eating Disorders²⁴

24. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

Problem/Intervention	Rationale
Nutrition • Monitor weight, caloric intake, and food behavior during meals. • Collaborate with dietitian to develop a structured, individualized meal plan. • Supervise meals and post-meal periods to prevent purging. • Monitor vital signs and signs of dehydration (dry mucosa, hypotension, tachycardia). • Assess lab values (K⁺, Na⁺, Mg⁺⁺, phosphate) frequently. • Monitor for bradycardia, hypotension, orthostatic changes, and arrhythmias. • Encourage oral fluid intake and restrict excessive water consumption (often used for weight manipulation).	Clients with eating disorders often experience malnutrition, electrolyte imbalances, and risk of refeeding syndrome. Structured support ensures gradual, safe nutritional rehabilitation. Electrolyte disturbances (especially hypokalemia) are life-threatening and common with vomiting, laxative use, and restriction. Malnutrition, purging, and starvation can lead to life-threatening cardiac changes, especially in anorexia. Early detection is critical to prevent sudden cardiac arrest. Close monitoring prevents cardiac and renal complications.
Sleep/Fatigue • Assess sleep patterns and disturbances. • Encourage consistent sleep-wake cycles and limit daytime naps. Provide periods of rest after activities, if needed. • Teach about relaxation techniques.	Anxiety, hyperactivity, and malnutrition often disrupt sleep. Adequate rest supports mood stabilization, cognition, and healing.

Elimination • Assess for constipation, diarrhea, or laxative abuse. • Encourage dietary fiber and hydration. • Educate on normal bowel patterns.	Disordered eating and purging can cause gastrointestinal dysfunction. Laxative abuse and food avoidance alter elimination patterns and must be managed to prevent long-term complications.
Activity and Exercise • Assess for compulsive or secretive exercise behaviors. • Set limits on physical activity during medical refeeding or low BMI states. • Provide alternative coping methods for emotional distress.	Excessive exercise is a common compensatory behavior in eating disorders and may worsen malnutrition and cardiac risk. Structured limits ensure safety during stabilization.
Self-Care Deficits • Assess ability to perform ADLs (e.g., bathing, grooming, dressing). • Reinforce positive self-care behaviors.	Severe malnutrition and depressive symptoms may lead to poor hygiene and low motivation. Encouraging self-care promotes dignity and recovery of function.

Communication Tips for Clients with Eating Disorders

Helpful communication techniques for building therapeutic rapport, fostering trust, and supporting recovery in individuals with eating disorders are described in the following box.

Communication Tips for Clients with Eating Disorders²⁵

- Use nonjudgmental, empathetic language.
 - **Rationale:** Clients with eating disorders often experience intense shame, guilt, or secrecy. An empathetic tone reduces defensiveness and encourages honesty and openness in discussing symptoms.
- Avoid focusing on weight or appearance.
 - **Rationale:** Commenting on weight, even positively, can reinforce disordered thinking. Instead, focus on behaviors, emotions, and health (e.g., “I noticed you seemed more energized today.”).
- Validate emotional experiences, not just behaviors.
 - **Rationale:** Acknowledge feelings behind behaviors (e.g., “It sounds like you were feeling overwhelmed when that happened.”). This builds trust and shifts focus from control to coping.
- Be consistent and set clear, supportive boundaries.
 - **Rationale:** Clients may test boundaries due to anxiety or control struggles. Consistent

25. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

expectations and compassionate firmness help them feel safe and contained.

- Normalize discussion of food and body image struggles.
 - **Rationale:** Statements like “Many people in recovery have similar fears” reduce isolation and stigma, encouraging clients to share more freely.
- Collaborate in goal setting.
 - **Rationale:** Involve clients in creating achievable recovery goals. This enhances autonomy and reduces resistance, especially in those who fear loss of control.
- Frame meal plans and interventions as health-supportive, not punitive. Use open-ended questions (such as, “What makes meals difficult for you?”) instead of coercion.
 - **Rationale:** Clients with eating disorders often experience intense fear, shame, and anxiety around food, eating, and body image. Their relationship with food is not merely about nutrition but is often deeply tied to control, self-worth, identity, or coping with distress. When meal plans and interventions are presented in a rigid or authoritative manner, clients may perceive them as punitive or threatening, which can lead to increased resistance or noncompliance.

Referral to Resources

Nurses refer clients and their loved ones to community resources. Examples of community resources are described in the following box.

Examples of Resources for Individuals with Eating Disorders

- ▶ [National Eating Disorders Association \(NEDA\)](#): Support, resources, and treatment options
- ▶ [Eating Disorders Resource Group](#): Resources including treatment apps
- ▶ [ANAD](#): Eating disorder peer support groups

Evaluation (Evaluate Outcomes)

Evaluation is a continuous process of reviewing a client's progress towards their individualized goals and SMART outcomes. Interventions are continually evaluated and modified based on their success in meeting these short-term goals.

Recovery is a long and difficult process. It is common for individuals to relapse. Attention should be paid to identifying triggers and warning signs of disordered eating before a relapse occurs. Ongoing support is critical to long term recovery. Potential long term medical consequences of eating disorders are neurological disease, cardiac damage, blood pressure complications and early onset osteoporosis.

General questions to include when evaluating a client's plan of care include the following:

- Has the patient's weight stabilized or moved closer to a healthy range?
- Are vital signs (e.g., heart rate, blood pressure, temperature) within normal limits?

- Have laboratory values (e.g., electrolytes, liver function) improved or normalized?
- Has the patient's menstrual cycle returned (if applicable)?
- Are physical symptoms (e.g., dizziness, fatigue, hair loss) improving?
- Is the patient adhering to a structured meal plan?
- Has the frequency of restrictive eating, binge eating, or purging behaviors decreased?
- Is the patient complying with treatment recommendations (e.g., attending therapy, following medical advice)?
- Are harmful behaviors (e.g., self-induced vomiting, laxative misuse, excessive exercise) being reduced or eliminated?
- Are the patient's relationships with family, friends, or peers improving?
- Is the patient participating in social activities, hobbies, or responsibilities they had previously avoided?
- Has the patient's overall quality of life and ability to function in daily life improved?
- Has the patient's preoccupation with food, weight, or body image decreased?
- Are there improvements in mood, anxiety, or emotional stability?
- Does the patient demonstrate increased insight into their illness and motivation for recovery?
- Is the patient developing healthier coping mechanisms to manage stress and emotions?

13.5 Spotlight Application

Consider these real-life stories of people who have struggled with eating disorders.

1. Princess Diana raised public awareness about eating disorders after sharing her experience with bulimia nervosa in recordings featured in the documentary *Diana: In Her Own Words*. After the publication, there was a sudden spike in the number of reported cases of bulimia, and many people came forward to receive the treatment they needed. Because of Diana's openness and honesty about her struggles with her eating disorder, countless people were empowered to be open and admit their own similar struggles.

▶ Read more about Princess Diana's experience in a NEDA blog titled [20 Years Later: How Princess Diana's Legacy Continues to Help People With Eating Disorders](https://staging.nationaleatingdisorders.org/princess-diana-legacy-people-with-eating-disorders/).¹

2. Mike Majama, a major league baseball player, experienced an eating disorder that impacted his sports career.

1. Sundquist, A. (n.d.). *20 years later: How Princess Diana's legacy continues to help people with eating disorders* [Blog]. National Eating Disorders Association. <https://staging.nationaleatingdisorders.org/princess-diana-legacy-people-with-eating-disorders/>

- ▶ Read a *Good Morning America* [interview](#) with Mike Majama.²

3. Karla Mosley, an actress on the television show *The Bold and the Beautiful*.

- ▶ Read an [NPR interview](#) with Karla Mosley.³

4. Veterans with eating disorders.

- ▶ Read a Connecticut Health Team [story](#) about veterans with eating disorders.⁴

2. Thorbecke, C. (2018). *MLB star opens up about his eating disorder struggles and overcoming his 'demons.'* ABC News Internet Ventures. <https://www.goodmorningamerica.com/wellness/story/mlb-star-opens-eating-disorder-struggles-overcoming-demons-54056732>

3. Meraji, S. M. (2019). *When it comes to race, eating disorders don't discriminate.* NPR. <https://www.npr.org/sections/health-shots/2019/03/03/699410379/when-it-comes-to-race-eating-disorders-dont-discriminate>

4. McCarthy, P. (2021). *Eating disorders among veterans attributed to trauma, military weight requirements.* Connecticut Health I-Team.

Reflective Questions

1. Compare and contrast the experiences of these individuals.
2. What strikes you most about these real-life stories?

<http://c-hit.org/2021/11/03/eating-disorders-among-veterans-attributed-to-trauma-military-weight-requirements/>

13.6 Learning Activities

(Answers to “Learning Activities” can be found in the “Answer Key” at the end of the book. Answers to the interactive activities are provided as immediate feedback.)

Case Study:

Tiffany is a 24-year-old nursing student who works weekends as a certified nursing assistant. Her sister Sara brought Tiffany to a clinic appointment with a nurse practitioner because of their family’s concerns about Tiffany’s weight and eating habits. During the intake process, Tiffany states, “I don’t think there is a problem; I just don’t want to be fat.” Tiffany is 5’7” and weighs 101 pounds in her street clothes, with a calculated BMI of 15.8. When asked to perform a 24-hour diet recall, Tiffany states, “I drink coffee for breakfast, eat a low-fat yogurt for lunch, and then eat a head of iceberg lettuce for dinner most days.” She cannot recall the last time she had a menstrual cycle. Tiffany states, “I used to run five miles every day, but lately I have been too tired to run.” She denies any purging episodes. Sara states, “Tiffany does not sit down and eat meals with the rest of us. We have tried everything and cannot get her to eat. My mom has tried talking to her, begging her, and even yelling at her. If Tiffany does eat something besides lettuce, she either goes in the bathroom and vomits or runs ten miles. We are very worried about her and don’t know what to do.”

Questions:

1. What symptoms of an eating disorder is Tiffany demonstrating?
2. What other assessments does the nurse plan for Tiffany?
3. What findings does the nurse anticipate as a result of a comprehensive assessment?
4. What laboratory tests will likely be ordered during this visit?
5. What is the goal of treatment for Tiffany?
6. What type of psychotherapy would be helpful for Tiffany?
7. What conditions would cause Tiffany to be hospitalized?
8. Tiffany is hospitalized. Create a brief nursing care plan for Tiffany including

a nursing diagnosis, SMART goal, and 3-5 nursing interventions.



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<https://wtcs.pressbooks.pub/nursingmhcc/?p=672#h5p-45>

1



An interactive H5P element has been excluded from this version of the text. You can view it online here:

<https://wtcs.pressbooks.pub/nursingmhcc/?p=672#h5p-46>

2

1. "MH Eating Disorders Glossary Cards" by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)
2. "MH Eating Disorders Question Set 1" by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)

- ▶ Test your clinical judgment with an NCLEX Next Generation-style question: [Chapter 13, Assignment 1](#)³



- ▶ Test your clinical judgment with an NCLEX Next Generation-style case study: [Chapter 13, Case Study 1](#)⁴



3. "MH Eating Disorders Next Gen Question by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)

4. "MH Eating Disorders Next Gen Case Study by Kellea Ewen is licensed under [CC BY-NC 4.0](#)

XIII Glossary

Amylophagia: Starch eating.

Anorexia nervosa: A condition where people avoid food, severely restrict food, or eat very small quantities of only certain foods.

Avoidant restrictive food intake disorder (ARFID): A condition where individuals limit the amount or type of food eaten.

Binge eating disorder: A condition where people lose control over their eating and have recurring episodes of eating unusually large amounts of food. Unlike bulimia nervosa, periods of binge eating are not followed by purging, excessive exercise, or fasting.

Binge eating episode: An episode characterized by both eating in a discrete period of time (e.g., within any two-hour period) an amount of food that is definitely larger than what most individuals would eat and a sense of a lack of control over eating during the episode; followed by purging behaviors.

Binge-Eating/Purging Type: Individuals experience episodes of binge eating and/or purging.

Body mass index (BMI): A person's weight in kilograms divided by the square of height in meters.

Bulimia nervosa: A condition where people have recurrent and frequent episodes of eating unusually large amounts of food and feeling a lack of control over these episodes.

Emaciation: A condition of extreme thinness.

Family-based therapy: A type of psychotherapy in which parents take an active role in managing their child's eating behaviors and weight restoration.

Geophagia: Clay eating.

Lanugo: Growth of fine hair all over the body.

Pagophagia: Ice eating.

Pica: An eating disorder in which an individual repeatedly eats things that are not considered food with no nutritional value, such as paper, dirt, soap, hair, glue, or chalk.

Purging: Behavior in eating disorders used to compensate for overeating, such as forced vomiting, excessive use of laxatives, or diuretics.

Refeeding syndrome: A potentially fatal complication for any client with negligible food intake for more than five days that involves hypophosphatemia; serious sodium and fluid imbalances; changes in glucose, protein, and fat metabolism; thiamine deficiency; hypokalemia; and hypomagnesaemia.

Restricting Type: Individuals severely limit the amount and type of food they consume and may engage in excessive exercise.

Learning Objectives

- Identify assessment cues of substance use behaviors
- Identify nursing priorities for clients with substance use disorders
- Plan outcomes for clients with substance use disorders
- Differentiate safety/protective interventions for clients with substance use disorders
- Apply evidence-based practice when planning care and interventions for clients with substance use disorders
- Analyze treatments for clients with substance use disorders
- Apply the nursing process to clients with substance use disorders at risk for suicide
- Assess clients for signs of intoxication, dependency, and withdrawal symptoms and intervene appropriately
- Apply the nursing process to clients experiencing withdrawal or toxicity from substances
- Describe care for clients with nonsubstance-related dependencies (e.g., gambling, sexual addiction)
- Describe the neurobiology and risk factors for substance use disorders
- Describe protective factors and prevention programs for substance use disorders

Misuse of alcohol, drugs, and prescribed medications is estimated to cost the United States more than \$400 billion in health care expenses, law enforcement and criminal justice costs (due to drug-related crimes), lost

workplace productivity, and losses from motor vehicle crashes.¹ The Centers for Disease Control and Prevention (CDC) National Center for Health Statistics estimates 107,622 drug overdose deaths and 52,000 alcohol-induced deaths occurred in the United States in 2021.²

- ▶ View a visualization of recent drug overdose death rates nationally and by state at the CDC National Center for Health Statistics' Vital Statistics Rapid Release web page: [Provisional Drug Overdose Death Counts](#).

Substance use disorders significantly impact individuals, families, communities, and our society. According to the 2020 National Survey on Drug Use and Health (NSDUH), 40.3 million people in the United States aged 12 or older (14.5 percent) have a substance use disorder (SUD).³

This chapter will provide an overview of many topics related to substance use. It begins by reviewing signs of intoxication of various psychoactive substances and treatment for overdose and withdrawal symptoms. The neurobiology of substance use disorders and risk factors are explored, and then evidence-based treatment and prevention interventions are discussed based on the

1. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
2. National Center for Health Statistics. (2022). *U.S. overdose deaths in 2021 increased half as much in 2020 – but are still up 15%* [Press release]. https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/202205.htm
3. National Survey on Drug Use and Health. (n.d.). <https://nsduhweb.rti.org/respweb/homepage.cfm>

Surgeon General's Report on Alcohol, Drugs, and Health PDF. Finally, the nursing process is applied to a hospitalized client receiving treatment for alcohol withdrawal.

14.2 Substances: Use, Intoxication, and Overdose

A **substance** is defined as a psychoactive compound with the potential to cause health and social problems, including substance use disorder. Substances can be divided into four major categories: alcohol, illicit drugs (including nonmedical use of prescription drugs), over-the-counter drugs, and other substances. See examples of substances known to have a significant public health impact in Table 14.2a. **Substance use** refers to the use of any of the psychoactive substances listed in Table 14.2a.

Table 14.2a Categories and Examples of Substances¹

Substance Category	Examples
Alcohol	Beer, malt liquor, wine, and distilled spirits
Illicit drugs (including prescription drugs used nonmedically)	• Opioids, including heroin • Cannabis • Sedatives, hypnotics, and anxiolytics • Hallucinogens • Stimulants, including methamphetamine-like substances, cocaine, and crack • Dextromethorphan and other cold medications
Over-the-counter drugs (used nonmedically)	Dextromethorphan, pseudoephedrine, and other cold medications
Other substances	Inhalants such as spray paint, gasoline, and cleaning solvents; Delta-8 THC

1. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

Millions of Americans misuse substances. See Figure 14.1² regarding the number of people aged 12 and older who reported using various substances in a one-month period of time.

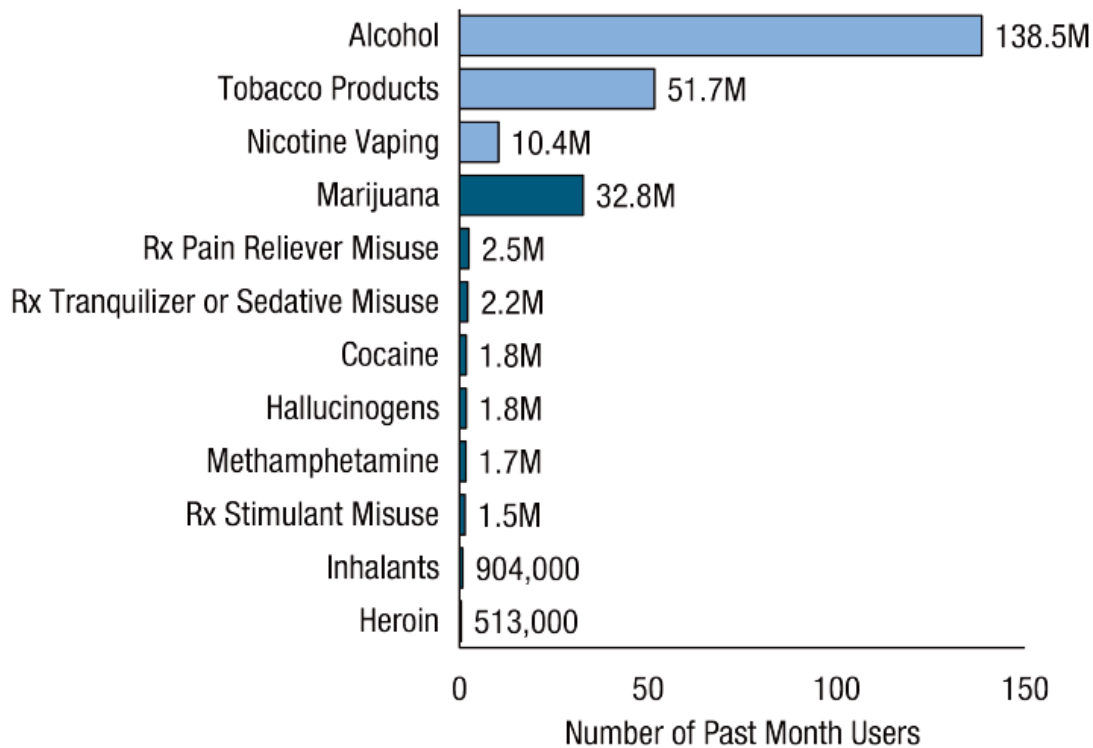


Figure 14.1 Number of People Aged 12 and Older Who Reported Using Substances in the Past Month in 2020. Used under Fair Use.

2. This image is a derivative of “Past Month General Substance Use and Nicotine Vaping: Among People Aged 12 and Older; 2020” table by [Substance Abuse and Mental Health Services Administration](#). (2021). Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health (HHS Publication No. PEP21-07-01-003, NSDUH Series H-56). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Used under Fair Use. Retrieved from <https://www.samhsa.gov/data/report/2020-nsduh-annual-national-report>

Controlled Substances

The Controlled Substances Act is a federal law that places all **controlled substances** (i.e., substances regulated by the U.S. Drug Enforcement Agency) into one of five categories called schedules. This placement is based on the substance’s medical use, its potential for abuse or dependency, and related safety issues. For example, Schedule I drugs have a high potential for abuse and potentially cause severe psychological and/or physical dependence, whereas Schedule V drugs represent the least potential for abuse.³

Dependence means that when a person suddenly stops using a drug, their body goes through **withdrawal**, a group of physical and mental symptoms that can range from mild to life-threatening. See examples of controlled substances categorized by schedule in Table 14.2b.

Table 14.2b Examples of Substances by Schedule⁴

- 3. United States Drug Enforcement Administration. (n.d.). *The Controlled Substance Act. U.S. Department of Justice.* <https://www.dea.gov/drug-information/csa>
- 4. United States Drug Enforcement Administration. (n.d.). *The Controlled Substance Act. U.S. Department of Justice.* <https://www.dea.gov/drug-information/csa>

Schedule	Definition	Examples
Schedule I	No currently accepted medical use and a high potential for abuse.	Heroin, LSD, MDMA (Ecstasy), and cannabis (marijuana)
Schedule II	High potential for abuse, with use potentially leading to severe psychological or physical dependence. These drugs are also considered dangerous.	Hydrocodone, cocaine, methamphetamine, methadone, hydromorphone, meperidine, oxycodone, fentanyl, amphetamine/dextroamphetamine salts (Adderall), methylphenidate (Ritalin), and phencyclidine (PCP)
Schedule III	Moderate to low potential for physical and psychological dependence. Abuse potential is less than Schedule I and Schedule II drugs but more than Schedule IV.	Acetaminophen with codeine, ketamine, anabolic steroids, and testosterone
Schedule IV	Low potential for abuse and low risk of dependence.	Alprazolam (Xanax), diazepam (Valium), lorazepam (Ativan), zolpidem (Ambien), and tramadol (Ultram)
Schedule V	Lower potential for abuse than Schedule IV and consist of preparations containing limited quantities of certain narcotics. Generally used for antidiarrheal, antitussive, and analgesic purposes.	Cough medications with codeine, diphenoxylate/atropine (Lomotil), and pregabalin (Lyrica)

► See the [DEA alphabetized list of controlled substances PDF](#).

Substance Misuse

Substance misuse is defined as the use of alcohol or drugs in a manner, situation, amount, or frequency that could cause harm to the user or to those

around them.⁵ Substance misuse can involve a wide range of substances, including alcohol, illicit drugs, prescription medications, over-the-counter drugs, and inhalants. Misuse can be of low severity and temporary, but it can increase the risk for serious and costly consequences such as motor vehicle crashes, overdose death, suicide, various types of cancer, heart, liver, and pancreatic/liver diseases, HIV/AIDS, and unintended pregnancies. Substance use during pregnancy can cause complications for the baby such as fetal alcohol spectrum disorders (FASDs) or neonatal abstinence syndrome (NAS). Substance misuse is also associated with intimate partner violence, child abuse, and neglect.⁶

Substance abuse, an older diagnostic term, referred to unsafe substance use (e.g., drunk or drugged driving), use that caused legal problems, or use that continued despite failure to meet work and family responsibilities. However, the term “substance abuse” is now avoided by professionals because it does not accurately account for the neurobiological knowledge we now have about addictive disorders. Instead, the term “substance use disorder” is preferred and is further discussed in the “[Substance Use Disorder](#)” subsection of this chapter.⁷

5. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
6. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
7. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

Intoxication and Overdose

Intoxication refers to a disturbance in behavior or mental function during or after the consumption of a substance. **Overdose** is the biological response of the human body when too much of a substance is ingested. Signs of intoxication and overdose for categories of psychoactive substances are described in the following subsections.

Anyone can call a regional poison control center at 1-800-222-1222 for consultation regarding toxic ingestion of substances and overdoses. Poison control centers are available at all times, every day of the year. Some hospitals also have toxicologists available for bedside consultation for overdoses.

Alcohol Use and Intoxication

Based on the 2015-2020 Dietary Guidelines for Americans, a **standard drink** is defined as 14 grams (0.6 ounces) of pure alcohol. Examples of a standard drink are one 12-ounce beer, 8 – 9 ounces of malt liquor, 5 ounces of wine, or 1.5 ounces of distilled spirits. See Figure 14.2⁸ for images of standard drinks.

8. "[NIH_standard_drink_comparison.jpg](#)" by [National Institutes of Health](#) is in the [Public Domain](#)

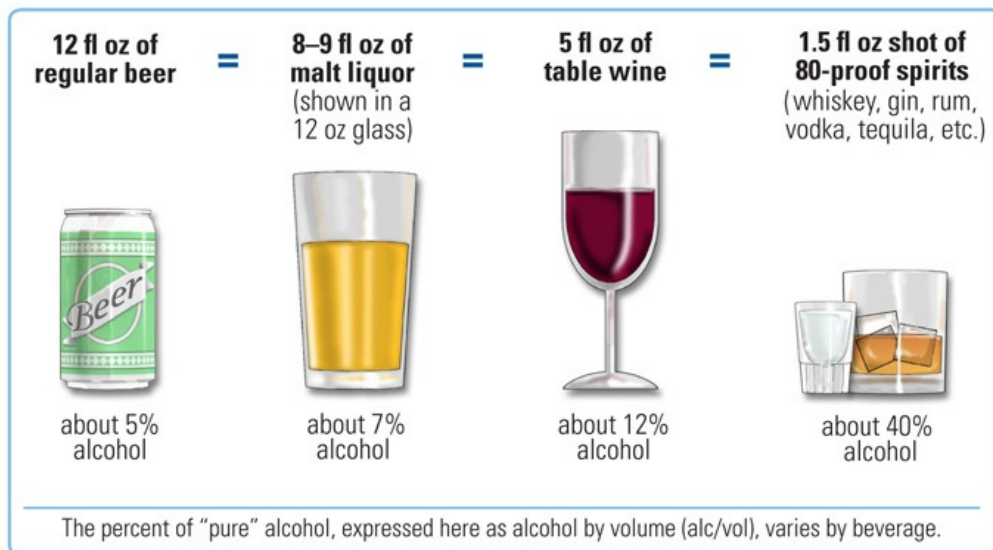


Figure 14.2 Standard Drink

The 2020 National Survey on Drug Use and Health reports that 50 percent (139.7 million) of Americans aged 12 or older use alcohol, 22.2 percent are binge drinkers, and 6.4 percent are heavy alcohol users.⁹ **Heavy drinking** is defined as a female consuming 8 or more drinks per week or a male consuming 15 or more standard drinks per week, or either gender binge drinking on 5 or more days in the past 30 days. **Binge drinking** is defined as consuming several standard drinks on one occasion in the past 30 days; for men, this refers to drinking five or more standard alcoholic drinks on one occasion, and for women this refers to drinking four or more standard drinks on one occasion.¹⁰

Alcohol intoxication refers to problematic behavioral or psychological changes (e.g., inappropriate sexual or aggressive behavior, mood lability, or impaired judgment) that develop during or shortly thereafter alcohol

9. National Survey on Drug Use and Health. (n.d.). <https://nsduhweb.rti.org/respweb/homepage.cfm>

10. National Survey on Drug Use and Health. (n.d.). <https://nsduhweb.rti.org/respweb/homepage.cfm>

ingestion. Signs and symptoms of alcohol intoxication include a range of behavioral, neurological, and systemic effects. Some examples include¹¹:

- Slurred speech
- Incoordination
- Unsteady gait
- Nystagmus
- Impairment in attention or memory
- Nausea/vomiting

ALCOHOL OVERDOSE

An alcohol overdose occurs when there is so much alcohol in the bloodstream that areas of the brain controlling autonomic nervous system functions (e.g., breathing, heart rate, and temperature control) begin to shut down. Alcohol intoxication while also taking opioids or sedative-hypnotics (such as benzodiazepines or sleep medications) increases the risk of an overdose. Alcohol overdose can cause permanent brain damage or death.¹² Anyone who consumes too much alcohol too quickly is in danger of an alcohol overdose, especially for individuals who engage in binge drinking. As blood alcohol concentration (BAC) increases, so does the risk of harm. When BAC reaches high levels, blackouts (gaps in memory), loss of consciousness (passing out), and death can occur. BAC can continue to rise even when a person stops drinking or is unconscious because alcohol in the stomach and intestine

11. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

12. National Institute on Alcohol Abuse and Alcoholism, & National Institutes of Health. (2024). *Understanding the dangers of alcohol overdose*. <https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/understanding-dangers-of-alcohol-overdose>

continues to enter the bloodstream and circulate throughout the body. See Figure 14.3¹³ for the impairments related to rising BAC.

13. “NIAAA_BAC_Increases_Graphic.jpg” by [The National Institute on Alcohol Abuse and Alcoholism](#) is in the [Public Domain](#). Access for free at <https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/understanding-dangers-of-alcohol-overdose>

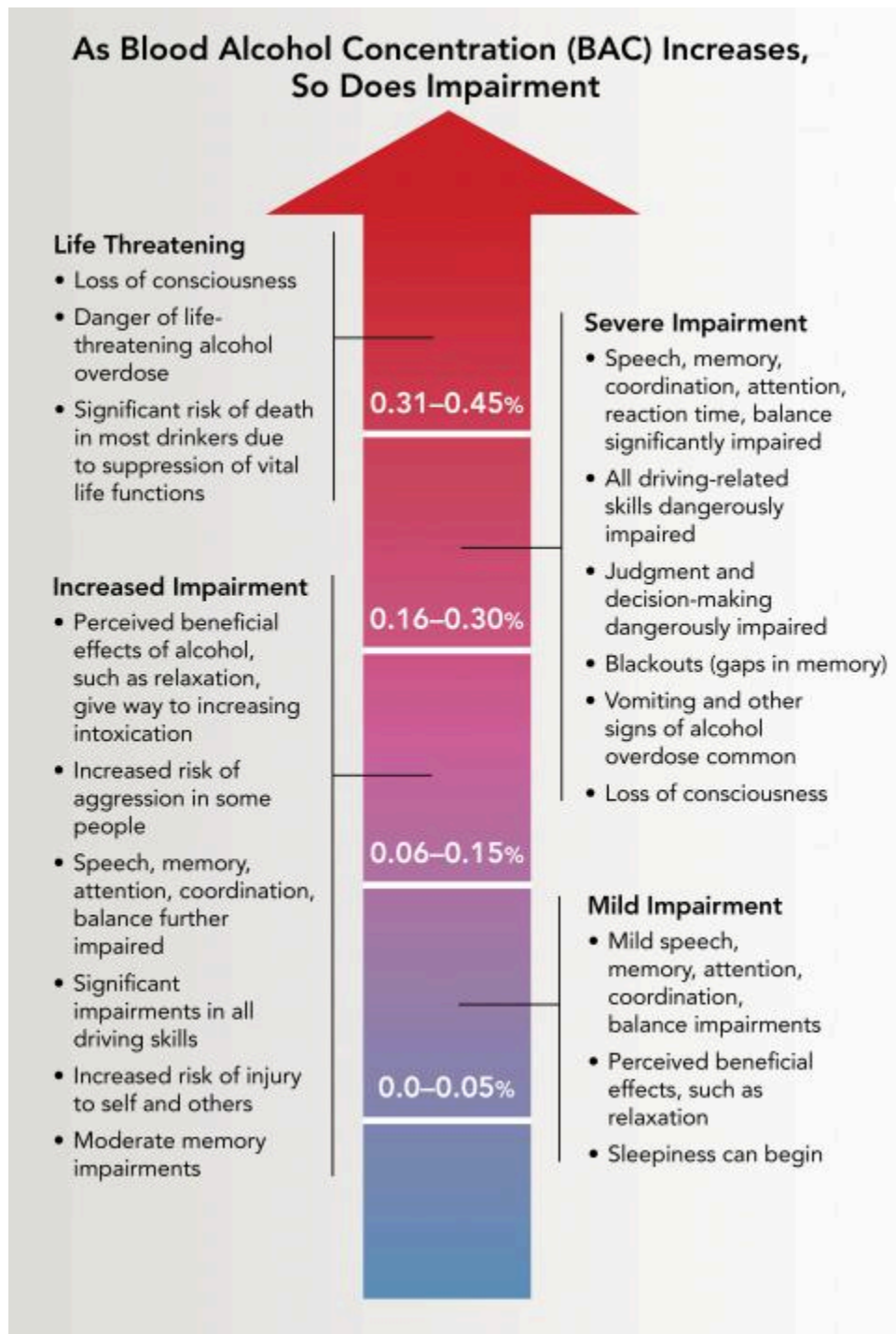


Figure 14.3 Impairments of Rising Blood Alcohol Concentrations

It is dangerous to assume that a person who drank an excessive amount of alcohol will “sleep it off.” One potential danger of alcohol overdose is choking on one’s vomit and dying from lack of oxygen because high levels of alcohol intake hinder the gag reflex, resulting in the inability to protect the airway. Asphyxiation can occur due to an obstructed airway or from aspiration of gastric contents into the lungs. For this reason, do not leave a person alone

who has passed out due to alcohol misuse. Keep them in a partially upright position or roll them onto one side with an ear toward the ground to prevent choking if they begin vomiting.¹⁴ Critical signs and symptoms of an alcohol overdose include the following¹⁵ :

- Mental confusion or stupor
- Difficulty remaining conscious or inability to wake up
- Vomiting
- Seizures
- Slow respiratory rate (fewer than 8 breaths per minute)
- Irregular breathing (10 seconds or more between breaths)
- Slow heart rate
- Clammy skin
- Dulled responses, such as no gag reflex (which prevents choking)
- Extremely low body temperature
- Bluish skin color or paleness

MEDICAL TREATMENT OF ACUTE ALCOHOL INTOXICATION

Acute alcohol intoxication can cause hypotension and tachycardia as a result of peripheral vasodilation or fluid loss. Treatment begins with the evaluation of the client's blood alcohol level (BAC). The primary focus of care involves client stabilization and supportive care. This includes monitoring vital signs, ensuring airway protection, and preventing complications such as

14. National Institute on Alcohol Abuse and Alcoholism, & National Institutes of Health. (2024). *Understanding the dangers of alcohol overdose*.

<https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/understanding-dangers-of-alcohol-overdose>

15. National Institute on Alcohol Abuse and Alcoholism, & National Institutes of Health. (2024). *Understanding the dangers of alcohol overdose*.

<https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/understanding-dangers-of-alcohol-overdose>

hypoglycemia, hypotension, and electrolyte imbalances. It is important to know if other drugs like opioids, benzodiazepines, or street drugs have been ingested because this increases the risk of overdose, and other treatments (such as naloxone) may be required. For clients with moderate to severe intoxication, routine lab work includes serum glucose and electrolytes to assess for hypoglycemia, hypokalemia, hypomagnesemia, hypocalcemia, hypophosphatemia, and hyperlactatemia. If hypoglycemia is present, a dextrose intravenous infusion is provided.¹⁶ Severely intoxicated clients may receive intravenous thiamine, along with dextrose, to prevent Wernicke's encephalopathy. Wernicke's encephalopathy is an acute, life-threatening neurological condition characterized by nystagmus, ataxia, and confusion caused by thiamine (B1) deficiency associated with alcohol use disorder. Thiamine is required for cerebral energy utilization.¹⁷ If untreated, Wernicke's encephalopathy can progress to Korsakoff's syndrome, a chronic, irreversible memory disorder resulting from thiamine deficiency.¹⁸

Some clients with acute alcohol intoxication can become agitated, violent, and uncooperative. Chemical sedation with administration of benzodiazepines may be required to prevent the client from harming themselves or others. However, benzodiazepines must be used with caution because they worsen the respiratory depression caused by alcohol. Approximately one percent of clients with acute alcohol intoxication

16. Cowan, E., & Su, M. K. (2024). Ethanol intoxication in adults. In *UpToDate*. www.uptodate.com

17. Vasan, S., & Kumar, A. (2023). *Wernicke encephalopathy*. StatPearls [Internet]. <https://www.ncbi.nlm.nih.gov/books/NBK470344/>

18. National Institute of Neurological Disorders and Stroke. (n.d.). *Wernicke-Korsakoff syndrome*. [https://www.ninds.nih.gov/health-information/disorders/wernicke-korsakoff-syndrome#:~:text=Korsakoff%20syndrome%20\(also%20called%20Korsakoff's,t he%20brain%20involved%20with%20memory.](https://www.ninds.nih.gov/health-information/disorders/wernicke-korsakoff-syndrome#:~:text=Korsakoff%20syndrome%20(also%20called%20Korsakoff's,t he%20brain%20involved%20with%20memory.)

require critical care. Risk factors for admission to the intensive care unit (ICU) include abnormal vital signs (hypotension, tachycardia, fever, or hypothermia), hypoxia, hypoglycemia, and the need for parenteral sedation. If the client has inadequate respirations or airway maintenance, intubation and mechanical ventilation are required. Activated charcoal and gastric lavage are generally not helpful because of the rapid rate of absorption of alcohol from the gastrointestinal tract. Some acutely intoxicated clients experience head traumas from injuries sustained while intoxicated. If the client's mental status does not improve as their BAC level decreases, a CT scan of the head may be obtained.¹⁹

MEDICAL TREATMENT OF ALCOHOL OVERDOSE

In addition to the supportive care measures used for alcohol intoxication, treatment for alcohol overdose may require more aggressive interventions. This includes advanced airway management, mechanical ventilation if necessary, and intensive monitoring in an ICU setting.²⁰

Opioid Use and Intoxication

In 2020, 9.5 million (3.4%) of Americans aged 12 and older reported using opioids in the past year. Among this population, 9.3 million people misused prescription pain relievers, and 902,000 people used heroin.²¹ Opioids are substances that act on opioid receptors in the central nervous system. Medically, they are used for relief of moderate to severe pain and anesthesia.

19. Cowan, E., & Su, M. K. (2024). Ethanol intoxication in adults. In *UpToDate*. www.uptodate.com

20. Cowan, E., & Su, M. K. (2024). Ethanol intoxication in adults. In *UpToDate*. www.uptodate.com

21. National Survey on Drug Use and Health. (n.d.) <https://nsduhweb.rti.org/respweb/homepage.cfm>

When misused, opioids cause a person to feel relaxed and euphoric (i.e., experience an intense feeling of happiness). Opioid prescription medications include Schedule II medications such as morphine, oxycodone, hydrocodone, fentanyl, and hydromorphone. Heroin, an illegal street drug, is also an opioid, but it is classified as a Schedule I drug.²² Injected opioid misuse is a risk factor for contracting HIV, hepatitis B, hepatitis C, and bacterial endocarditis.²³

Opioid intoxication a condition where a person is affected by opioid drugs to the point of being impaired and potentially ill. It causes problematic behavioral or psychological changes such as initial euphoria followed by apathy, dysphoria, psychomotor retardation or agitation, and impaired judgment. These are some signs of opioid intoxication²⁴:

- Pupillary constriction (or dilation from severe overdose) and one of the following:
 - Drowsiness or coma
 - Slurred speech
 - Impairment in attention or memory

OPIOID OVERDOSE

From 1999 to 2019, nearly 500,000 people died from an overdose involving prescription or illicit opioids. This rise in opioid overdose deaths can be

22. A.D.A.M. Medical Encyclopedia [Internet]. (2022). *Opioid intoxication*.
<https://medlineplus.gov/ency/article/000948.htm>

23. Substance Abuse and Mental Health Services Administration. (2024). *Learn about substances*. U.S. Department of Health & Human Services.
<https://www.samhsa.gov/find-help/atod>

24. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

outlined in three distinct waves. See Figure 14.4²⁵ for an illustration of these three waves of opioid overdose. The first wave of overdose deaths began with the increased prescription rate of opioids in the 1990s. The second wave began in 2010 with rapid increases in overdose deaths involving heroin. The third wave began in 2013 with significant increases in overdose deaths involving synthetic opioids, particularly illicitly manufactured fentanyl.²⁶

There are two types of fentanyl: pharmaceutical fentanyl prescribed for severe pain, and illicitly manufactured fentanyl. Most recent cases of fentanyl-related overdose are associated with illicitly manufactured fentanyl that is added to other street drugs that make them more powerful, more addictive, and more dangerous.²⁷

25. “3-waves-2019-medium.PNG” by [The Centers for Disease Control and Prevention](#) is in the [Public Domain](#). Access for free at <https://www.cdc.gov/drugoverdose/epidemic/index.html>
26. Centers for Disease Control and Prevention. (2021). *Understanding the epidemic*. U.S. Department of Health & Human Services. <https://www.cdc.gov/drugoverdose/epidemic/index.html>
27. Centers for Disease Control and Prevention. (n.d.). *The facts about fentanyl* [PDF Handout]. https://www.cdc.gov/stopoverdose/fentanyl/pdf/fentanyl_fact_sheet_508c.pdf

Three Waves of the Rise in Opioid Overdose Deaths

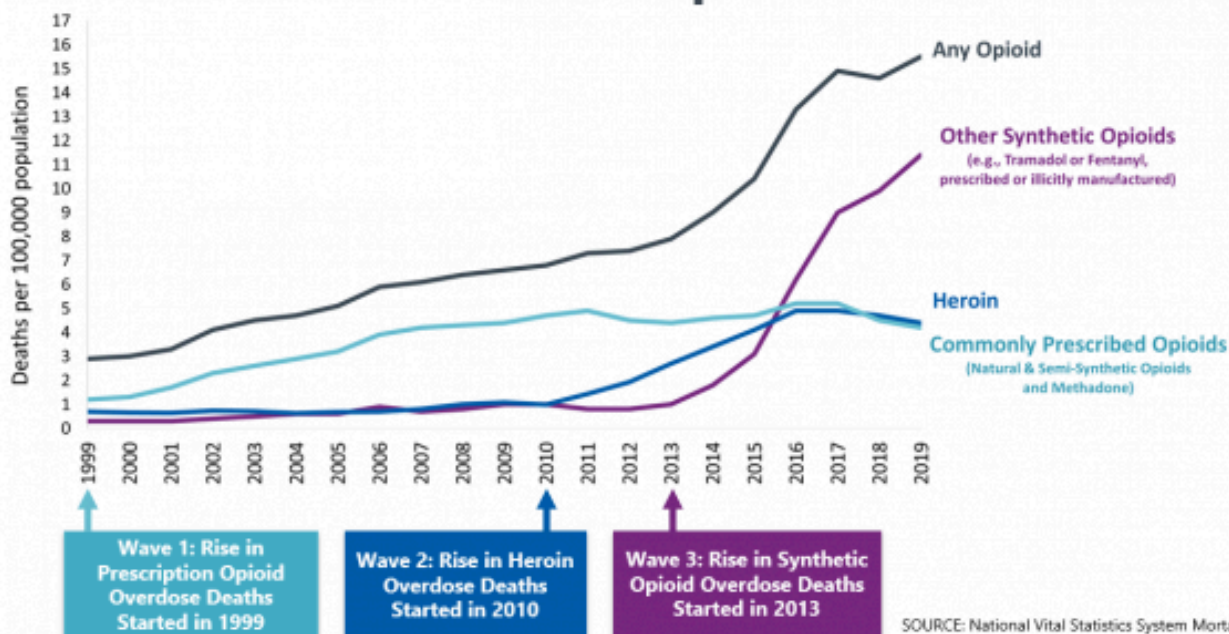


Figure 14.4 Three Waves of Opioid Overdose

Carfentanil is a new factor in opioid overdose rates. Carfentanil is a synthetic opioid used to tranquilize large mammals like elephants. It is approximately 10,000 times more potent than morphine and 100 times more potent than fentanyl. A miniscule amount of powder containing two milligrams of carfentanil can be lethal. Carfentanil can be accidentally absorbed through the skin or inhaled by unsuspecting parties. If carfentanil or another fentanyl-related drug is suspected to be present on an individual, first responders and health care professionals must carefully follow safety protocols to avoid accidental lethal exposure.²⁸ Signs of opioid overdose include the following:

- Unconsciousness or inability to awaken
- Pinpoint pupils
- Slow, shallow breathing; breathing difficulty manifested by choking sounds or a gurgling/snoring noise from a person who cannot be

28. Drug Enforcement Administration. (n.d.). *Officer safety alert*. U.S. Department of Justice. <https://www.justice.gov/usao-edky/file/898991/download>

awakened; or respiratory arrest

- Fingernails or lips turning blue or purple

▶ Read a U.S. Department of Justice Officer Safety Alert PDF:
[Carfentanil: A Dangerous New Factor in the U.S. Opioid Crisis.](#)

TREATING OPIOID OVERDOSE

Naloxone reverses the effects of an opioid overdose. A single-step nasal spray delivery of naloxone is the easiest and most successful route of administration for members of the community and first responders. Naloxone intramuscular injection is also available.²⁹

Five basic steps are recommended for nurses, first responders, health professionals, and other bystanders to rapidly recognize and treat opioid overdose to prevent death.³⁰

1. **Evaluate Signs of Overdose & Obtain Emergency Assistance:** If an opioid overdose is suspected, try to stimulate the person by calling their name or vigorously grinding one's knuckles into their sternum. If the person does

29. Eggleston, W., Podolak, C., Sullivan, R. W., Pacelli, L., Keenan, M., & Wojcik, S. (2018). A randomized usability assessment of simulated naloxone administration by community members. *Addiction*, 113(12), 2300-2304.
<https://doi.org/10.1111/add.14416>

30. Substance Abuse and Mental Health Services Administration. (2018). *SAMHSA opioid overdose prevention toolkit: Five essential steps for first responders* [PDF Manual]. U.S. Department of Health & Human Services.
<https://store.samhsa.gov/sites/default/files/d7/priv/five-essential-steps-for-first-responders.pdf>

not respond, call 911 or obtain emergency assistance.

2. **Provide Rescue Breathing, Chest Compressions, and Oxygen as Needed**

- Provide rescue breathing if the person is not breathing on their own. A barrier device is recommended to reduce the risk of disease transmission. Rescue breathing for adults involves the following steps:
 - Be sure the person's airway is clear.
 - Place one hand on the person's chin, tilt the head back, and pinch the nose closed.
 - Place your mouth over the person's mouth to make a seal and give two slow breaths.
 - Watch for the person's chest (but not the stomach) to rise.
 - Follow up with one breath every five seconds.
- If the individual becomes pulseless, provide cardiopulmonary resuscitation (CPR).
- Administer oxygen as needed.

3. **Administer the First Dose of Naloxone**

- Naloxone should be administered to anyone suspected of an opioid overdose when there is evidence of significant respiratory depression or CNS depression.
- Research has shown that women, older adults, and those without obvious signs of opioid use disorder are undertreated with naloxone and, as a result, have a higher death rate. Therefore, naloxone should be considered for women and the elderly who are found unresponsive.
- Naloxone can be used in life-threatening opioid overdose circumstances in pregnant women.
- Naloxone can be given intranasally, intramuscularly, subcutaneously, or intravenously. The nasal spray is a prefilled device that requires no assembly and delivers a single dose into one nostril. An auto-injector is injected into the outer thigh to deliver naloxone intramuscularly or subcutaneously.

- All naloxone products are effective in reversing opioid overdose, including fentanyl-involved opioid overdoses, although overdoses involving potent or large quantities of opioids may require additional doses of naloxone.
- Withdrawal triggered by naloxone can feel unpleasant; some people may awaken confused, agitated, or aggressive. Provide safety, reassurance, and explain what is happening.

4. Administer a Second Dose of Naloxone If the Person Does Not Respond:

- If the person overdosing does not respond within 2 to 3 minutes after administering a dose of naloxone, administer a second dose of naloxone.
- People who have taken long-acting or potent opioids (like fentanyl) may require additional intravenous bolus doses or an infusion of naloxone.
- The duration of effect of naloxone depends on dose, route of administration, and overdose symptoms. It is shorter than the effects of some opioids, so a second dose may be required.

5. Monitor the Person's Response:

- Most people respond to naloxone by returning to spontaneous breathing within 2 to 3 minutes. Continue resuscitation while waiting for the naloxone to take effect.
- The goal of naloxone therapy is to restore adequate spontaneous breathing but not necessarily achieve complete arousal.
- The individual should be monitored for recurrence of signs and symptoms of opioid toxicity for at least four hours from the last dose of naloxone. People who have overdosed on long-acting opioids like fentanyl require prolonged monitoring.
- Because naloxone has a relatively short duration of effect, overdose symptoms may return. Therefore, it is essential to get the person to an emergency department or other source of medical care as quickly as possible, even if the person revives after the initial dose of naloxone.

and seems to feel better.

PREVENTING ILLICIT DRUG OVERDOSE

Nearly 85% of overdose deaths involve illicitly manufactured fentanyl, heroin, cocaine, or methamphetamine. Potential opportunities to link people to care or to implement life-saving actions have been identified for more than 3 in 5 people who died from drug overdose. Circumstances that represent a potential touchpoint for linkage to care are as follows³¹:

- **Bystander present:** Nearly 40% of opioid and stimulant overdose deaths occurred while a bystander was present.
- **Recent release from an institution:** Among the people who died from overdoses involving opioids, about 10% had recently been released from an institution (such as jail/prison, inpatient rehabilitation facilities, or psychiatric hospitals). Risk increased for this population because they were unaware of decreased tolerance to the drug due to abstinence from it while in the institution.
- **Previous overdose:** Among the people who died from overdoses involving opioids, about 10% had a previous overdose.
- **Mental health diagnosis:** Among all the people who died of a drug overdose, 25% had a documented mental health diagnosis.
- **Substance use disorder treatment:** Among the people who died from opioid overdose, nearly 20% had previously been treated for substance use disorder.

Opioid overdoses can be prevented by helping individuals struggling with opioid use disorder find the right treatment and recovery services, as well as

31. Centers for Disease Control and Prevention. (2020). *Overdose deaths and the involvement of illicit drugs*. U.S. Department of Health & Human Services. <https://www.cdc.gov/drugoverdose/featured-topics/VS-overdose-deaths-illicit-drugs.html>

providing public education about administering naloxone. See Figure 14.5.³² for an image related to these strategies.³³ Read more about treatment and recovery in the “[Treatment of Substance Use Disorders](#)” section.



Figure 14.5 Preventing Overdose Deaths

32. “prevent-overdose-deaths-71k-large.jpg” by [Centers for Disease Control and Prevention](#), [National Center for Injury Prevention and Control](#) is in the [Public Domain](#). Access for free at <https://www.cdc.gov/drugoverdose/resources/graphics/overdose.html>
33. Centers for Disease Control and Prevention. (2020). *Overdose deaths and the involvement of illicit drugs*. U.S. Department of Health & Human Services. <https://www.cdc.gov/drugoverdose/featured-topics/VS-overdose-deaths-illicit-drugs.html>

Cannabis (Marijuana) Use and Intoxication

Approximately 48.2 million (17.5 percent) of Americans aged 12 or older used cannabis (marijuana) in the past year, and 14.2 million people (5.1%) have a cannabis use disorder.³⁴ Changes in marijuana policies across states have legalized marijuana for recreational and/or medicinal uses (e.g., pain control, increased appetite for individuals undergoing chemotherapy, intractable seizures, etc.). Although many states now permit dispensing marijuana for medicinal purposes, the U.S. Food and Drug Administration has not approved “medical marijuana.” Therefore, it is important for nurses to educate people about both the adverse health effects and the potential therapeutic benefits linked to marijuana.³⁵

The main psychoactive chemical in marijuana is Delta-9-tetrahydrocannabinol (THC). THC alters the functioning of the hippocampus and other areas of the brain that enable a person to form new memories and shift their attentional focus. As a result, marijuana causes impaired thinking and interferes with a person’s ability to learn and perform complicated tasks. THC also disrupts functioning of the cerebellum and basal ganglia that regulate balance, posture, coordination, and reaction time. For this reason, people who have used marijuana may not drive safely and may have problems playing sports or engaging in other physical activities.³⁶

When marijuana is smoked, THC and other chemicals pass from the lungs into the bloodstream and are rapidly carried to the brain. The person begins

34. National Institute on Drug Abuse. (2020). *Marijuana research report*.
<https://nida.nih.gov/publications/research-reports/marijuana/letter-director>

35. National Institute on Drug Abuse. (2020). *Marijuana research report*.
<https://nida.nih.gov/publications/research-reports/marijuana/letter-director>

36. National Institute on Drug Abuse. (2020). *Marijuana research report*.
<https://nida.nih.gov/publications/research-reports/marijuana/letter-director>

to experience effects such as euphoria and sense of relaxation almost immediately. Other common effects include heightened sensory perception (e.g., brighter colors), laughter, altered perception of time, and increased appetite. Other people experience anxiety, fear, distrust, or panic, especially if they take too much, the marijuana has high potency, or the person is inexperienced in using cannabis. People who have taken large or highly potent doses of marijuana may experience acute psychosis, including hallucinations, delusions, and a loss of the sense of personal identity.³⁷

If marijuana is consumed in foods or beverages, the effects are delayed for 30 minutes to 1 hour, because the drug must first pass through the digestive system. Eating or drinking marijuana delivers significantly less THC into the bloodstream. Because of the delayed effects, people may inadvertently consume more THC than they intend to.³⁸ Although detectable amounts of THC may remain in the body for days or even weeks after use, the noticeable effects of smoked marijuana generally last from 1 to 3 hours, and marijuana consumed in food or drink may last for many hours.³⁹

Delta-8 THC products are manufactured from hemp-derived cannabidiol (CBD) and have psychoactive and intoxicating effects similar to Delta-9 THC. Some Delta-8 THC products are labeled as “hemp products,” which can mislead consumers who associate “hemp” with being non-psychoactive. Delta-8 THC is available for purchase online and in stores but has not been approved by the U.S. Food and Drug Administration for safe use in any context. It should be kept out of reach of children and pets. Some

37. National Institute on Drug Abuse. (2020). *Marijuana research report*.
<https://nida.nih.gov/publications/research-reports/marijuana/letter-director>

38. National Institute on Drug Abuse. (2020). *Marijuana research report*.
<https://nida.nih.gov/publications/research-reports/marijuana/letter-director>

39. National Institute on Drug Abuse. (2020). *Marijuana research report*.
<https://nida.nih.gov/publications/research-reports/marijuana/letter-director>

manufacturers use unsafe chemicals to make Delta-8 THC through a chemical synthesis process that can contaminate the end product. As a result, there has been a recent increase in reports of adverse events with 8% of cases requiring admission to a critical care unit.⁴⁰

THC affects brain systems that are still maturing through young adulthood, so regular use by teens may have negative and long-lasting effects on their cognitive development. Marijuana smoking is associated with large airway inflammation, increased airway resistance, lung hyperinflation, and chronic bronchitis. Vaping products that contain THC are associated with serious lung disease and death. Also, contrary to popular belief, marijuana can be addictive. THC stimulates neurons in the brain's reward system to release higher levels of dopamine and encourages the brain to repeat the rewarding behavior.⁴¹

Cannabis intoxication is defined as problematic behavior or psychological changes (e.g., impaired motor coordination, euphoria, anxiety, sensation of slowed time, impaired judgment, social withdrawal) that developed during or shortly after cannabis use. Signs and symptoms of cannabis intoxication include a range of acute psychological and physiological effects, which include some of the following⁴²:

- Conjunctival redness

40. U.S. Food & Drug Administration. (2022). *5 things to know about Delta-8 tetrahydrocannabinol – Delta-8 THC*. <https://www.fda.gov/consumers/consumer-updates/5-things-know-about-delta-8-tetrahydrocannabinol-delta-8-thc>

41. National Institute on Drug Abuse. (2020). *Marijuana research report*. <https://nida.nih.gov/publications/research-reports/marijuana/letter-director>

42. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

- Increased appetite
- Dry mouth
- Tachycardia

CANNABIS OVERDOSE

According to the CDC, a fatal overdose caused solely by marijuana is unlikely. However, effects from marijuana can lead to unintentional injury, such as a motor vehicle crash, fall, or poisoning. Overconsumption of marijuana can occur when using marijuana-infused products like edibles and beverages because it can take up to two hours to feel the effects from the drug.⁴³ Additionally, marijuana purchased as a street drug may be laced with other substances like synthetic fentanyl that can cause overdose.

The potential medicinal properties of marijuana and THC have been the subject of research and heated debate for decades. THC itself has proven medical benefits in particular formulations. For example, the U.S. Food and Drug Administration (FDA) has approved the use of THC-based oral medications dronabinol (Marinol) and nabilone (Cesamet) for the treatment of nausea in clients undergoing cancer chemotherapy and to stimulate appetite in clients with wasting syndrome due to AIDS.⁴⁴ Marijuana is also used by individuals with certain illnesses such as multiple sclerosis for the management of spasticity, tics, convulsions, and dyskinesia.⁴⁵ It can also be

43. Centers for Disease Control and Prevention. (2025). *Cannabis frequently asked questions*. U.S. Department of Health & Human Services.
https://www.cdc.gov/cannabis/faq/?CDC_AAref_Val=https://www.cdc.gov/marijuana/faqs.htm
44. National Institute on Drug Abuse. (2020). *Marijuana research report*.
<https://nida.nih.gov/publications/research-reports/marijuana/letter-director>
45. Shepard, S. (2021). *Can medical marijuana help your MS?* WebMD.
<https://www.webmd.com/multiple-sclerosis/multiple-sclerosis-medical->

used for symptom management in other diseases such as epilepsy, Alzheimer's Disease, Crohn's Disease, PTSD, and glaucoma.

MEDICAL TREATMENT FOR CANNABIS INTOXICATION

Treatment of cannabis intoxication is generally supportive. Most cases are mild and self-limited, requiring no formal medical intervention. Clients should be placed in a quiet environment and offered reassurance. Severe agitation or anxiety can be managed with benzodiazepines. If psychotic symptoms are present, second-generation antipsychotic agents may be used, with dosages adjusted based on the severity of the symptoms. In cases involving severe mood or psychotic symptoms, inpatient treatment may be warranted. For children who ingest cannabis, more severe symptoms such as coma, convulsions, or cardiopulmonary instability may develop, necessitating more intensive medical care.⁴⁶

Sedative, Hypnotic, and Anxiolytic Use and Intoxication

Examples of medications in the sedative, hypnotic, or anxiolytic class include benzodiazepines, such as alprazolam (Xanax), diazepam (Valium), lorazepam (Ativan), chlordiazepoxide (Librium), and clonazepam (Klonopin). An example of a hypnotic is zolpidem (Ambien). Although these are prescription medications, they are commonly misused.

Chronic use of benzodiazepines causes changes in gamma-aminobutyric acid (GABA) receptors, resulting in decreased GABA activity and the

[marijuana#:~:text=Surveys%20show%20that%20many%20people%20with%20MS%20already,that%20attacks%20your%20brain%2C%20spinal%20cord%2C%20and%20nerves.](#)

46. Gorelick, D.A. (2023). Cannabis-related disorders and toxic effects. *New England Journal of Medicine*, 389(24), 2267-2275. doi: 10.1056/NEJMr2212152

development of tolerance. When benzodiazepines are no longer present, or suddenly present at lower doses, withdrawal occurs.

Sedatives, hypnotics, and anxiolytic intoxication cause behavioral or psychological changes similar to alcohol intoxication, such as inappropriate sexual or aggressive behavior, mood lability, and impaired judgment. Symptoms of intoxication are as follows⁴⁷:

- Slurred speech
- Incoordination
- Unsteady gait
- Nystagmus
- Impaired cognition (attention and memory)
- Stupor or coma

Benzodiazepines are not detected by standard urine tests for drugs of abuse. However, specific benzodiazepine urine tests identify the metabolites of some benzodiazepines.⁴⁸

SEDATIVE, HYPNOTIC, AND ANXIOLYTIC OVERDOSE

Benzodiazepines cause CNS depression and are commonly involved in drug overdose. They are often co-ingested with other drugs, such as alcohol or opioids that cause stupor, coma, and respiratory depression. When treating benzodiazepine overdose, end tidal CO₂ (i.e., capnography) is used to monitor clients at risk for hypoventilation. Endotracheal intubation and mechanical

47. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

48. Greller, H., & Gupta, A. (2024). Benzodiazepine poisoning. *UpToDate*.
www.uptodate.com

ventilation may be required.^{49,50} Flumazenil is an antidote to reverse benzodiazepine-induced sedation following general anesthesia and procedural sedation. However, it is used cautiously for benzodiazepine overdose because it is associated with withdrawal seizures in individuals who have developed a tolerance to benzodiazepines.

Medical Treatment for sedative, hypnotic, and anxiolytic overdose include supportive care and pharmacotherapy. Supportive care involves securing the airway, providing respiratory support, and ensuring adequate circulation. This may involve bag-mask ventilation and, if necessary, endotracheal intubation and mechanical ventilation. Medication intervention includes the use of Flumazenil is a benzodiazepine antagonist that can be used to reverse the effects of benzodiazepines. The American Heart Association (AHA) guidelines recommend flumazenil in specific scenarios, such as pediatric exploratory ingestions and iatrogenic overdoses during procedural sedation, where high-risk conditions like chronic benzodiazepine dependence and coingestion of other dangerous substances can be reliably excluded. The initial dose for adults is 0.2 mg IV over 15 seconds, which can be repeated every 60 seconds up to a total of 1 mg.⁵¹

49. Kang, M., Galuska, M. A., & Ghassemzadeh, S. (2023). *Benzodiazepine toxicity*. StatPearls [Internet]. <https://www.ncbi.nlm.nih.gov/books/NBK482238/>
50. Greller, H., & Gupta, A. (2024). Benzodiazepine poisoning. *UpToDate*. www.uptodate.com
51. Lavonas, E. J., Akpunonu, P. D., Arens, A. M., Babu, K. M., Cao, D., Hoffman, R. S., Hoyte, C. O., Mazer-Amirshahi, M. E., Stolbach, A., St-Onge, M., Thompson, T. M., Wang, G. S., Hoover, A. V., & Drennan, I. R. (2023). 2023 American Heart Association focused update on the management of patients with cardiac arrest or life-threatening toxicity due to poisoning: An update to the American Heart Association guidelines for cardiopulmonary resuscitation and emergency cardiovascular care. *Circulation*, 148(16), e149-e184. [doi:10.1161/CIR.0000000000001161](https://doi.org/10.1161/CIR.0000000000001161).

Hallucinogen Use and Intoxication

In 2020, 7.1 million (2.6 percent) people in America aged 12 or older used hallucinogens.⁵² Hallucinogens are a diverse group of drugs that alter a person's awareness of their surroundings, as well as their own thoughts and feelings. They are commonly split into two categories: classic hallucinogens (such as LSD and peyote) and dissociative drugs (such as phencyclidine and ketamine). Dextromethorphan is an over-the-counter cough suppressant misused for its hallucinogenic and dissociative properties at high doses. It is important to note that ketamine is being utilized in monitored environments for pediatric pain control in emergency departments, acute and chronic pain management, depression and other mental health disorders.⁵³

Hallucinogens cause hallucinations (sensations and images that seem real though they are not), and dissociative drugs can cause users to feel out of control or disconnected from their bodies and environments. Historically, some cultures have used hallucinogens like peyote as a part of religious or healing rituals. Users of hallucinogens and dissociative drugs have increased risk for serious harm because of altered perceptions and moods. As a result, users might do things they would never do when not under the influence of a hallucinogen, like jump off a roof or act on suicidal thoughts..⁵⁴

Phencyclidine (PCP) is an example of a hallucinogen. It is an illegal street drug that usually comes as a white powder that can be inhaled through the nose,

52. National Survey on Drug Use and Health. (n.d.). <https://nsduhweb.rti.org/respweb/homepage.cfm>

53. Gao, M., Rejaei, D., & Liu, H. (2016). Ketamine use in current clinical practice. *Acta Pharmacologica Sinica*, 37(7), 865-72. [doi: 10.1038/aps.2016.5](https://doi.org/10.1038/aps.2016.5).

54. National Institute on Drug Abuse, & National Institutes of Health. (2023). *Psychedelics and dissociative drugs*. U.S. Department of Health & Human Services. <https://nida.nih.gov/research-topics/psychedelic-dissociative-drugs>

injected into a vein, smoked, or swallowed.⁵⁵ PCP intoxication causes problematic behavioral changes (e.g., belligerence, assaultiveness, impulsiveness, unpredictability, psychomotor agitation, impaired judgment) that occur during or shortly thereafter use.⁵⁶ Because of these symptoms, PCP is associated with violent and aggressive behavior including self-injury and violent criminal offenses (such as assaults, intimate partner violence, and homicide).⁵⁷ Within one hour of ingestion, two or more of the following signs or symptoms occur⁵⁸:

- Vertical or horizontal **nystagmus** (an involuntary eye movement that causes the eye to rapidly move up and down or from side to side)
- Hypertension
- Tachycardia
- Numbness or diminished responsiveness to pain
- Ataxia (impaired balance or coordination)
- Dysarthria
- Muscle rigidity
- Seizures or coma

55. A.D.A.M. Medical Encyclopedia [Internet]. Atlanta (GA): A.D.A.M., Inc.; c1997-2022. Substance use – phencyclidine (PCP); [updated 2022, February 18]. [https://medlineplus.gov/ency/patientinstructions/000797.htm#:~:text=Phencyclidine%20\(PCP\)%20is%20an%20illegal,into%20a%20vein%20\(shooting%20up\)](https://medlineplus.gov/ency/patientinstructions/000797.htm#:~:text=Phencyclidine%20(PCP)%20is%20an%20illegal,into%20a%20vein%20(shooting%20up))
56. American Psychiatric Association. (2013). *Desk reference to the diagnostic criteria from DSM-5*.
57. Crane, C. A., Easton, C. J., & Devine, S. (2013). The association between phencyclidine use and partner violence: An initial examination. *Journal of Addictive Diseases*, 32(2), 150–157. <https://doi.org/10.1080/10550887.2013.797279>.
58. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

- Hyperacusis (sensitivity to noise)

MEDICAL TREATMENT FOR HALLUCINOGEN INTOXICATION

Medical treatment for hallucinogen intoxication focuses primarily on supportive care and reassurance, as most cases are self-limiting. A calm, low-stimulation environment is essential to reduce sensory overload, anxiety, and disorientation. When significant agitation or anxiety is present, benzodiazepines such as lorazepam are typically the first-line treatment. In situations where a client exhibits severe psychomotor agitation or poses a risk to themselves or others, physical restraints may be necessary to ensure safety, followed by chemical sedation with intravenous benzodiazepines. If psychotic symptoms such as paranoia, delusions, or hallucinations are persistent and distressing, short-term use of antipsychotics may be indicated. In rare but severe cases, such as those involving hyperthermia, seizures, or cardiovascular instability, intensive care is required for close monitoring and life-saving interventions.⁵⁹ Review ANA guidelines on using restraints in the “[Client Rights](#)” section of the “Legal and Ethical Considerations in Mental Health Care” chapter and information on safely implementing restraints in the “[Workplace Violence](#)” section of the “Trauma, Abuse, and Violence” chapter.

HALLUCINOGEN OVERDOSE

Overdose can occur with some dissociative drugs like PCP. High doses of PCP can cause seizures, coma, and death, especially if taken with depressants such as alcohol or benzodiazepines.⁶⁰

59. Heard, K., & Hoppe, J. (2024). Phencyclidine(PCP) intoxication in adults. *UpToDate*. www.uptodate.com

60. National Institute on Drug Abuse, & National Institutes of Health. (2021). *Hallucinogens drug facts*. U.S. Department of Health & Human Services. <https://nida.nih.gov/publications/drugfacts/hallucinogens>

Dextromethorphan is an over-the-counter medication that is misused due to its hallucinogenic effects and can also cause overdose. Nonmedical use of dextromethorphan results in approximately 6,000 emergency department visits annually in the United States, often with co-ingestion of alcohol. Signs of toxic doses include neurobehavioral changes (e.g., hallucinations, inappropriate laughing, psychosis with dissociative features, agitation, and coma); tachycardia; dilated pupils; diaphoresis; and a “zombie-like” ataxic gait. Because acetaminophen is commonly present in cough and cold medications, toxic doses can cause severe delayed hepatotoxicity, hepatic failure, and death; serum acetaminophen levels should be obtained in all clients presenting with toxic levels of dextromethorphan.⁶¹

MEDICAL TREATMENT FOR HALLUCINOGEN OVERDOSE

The medical treatment for a hallucinogen overdose involves a combination of supportive care, symptomatic management, and pharmacologic interventions. For severe cases involving hyperthermia, seizures, or hypertensive crises, more intensive medical interventions may be necessary, including cooling measures and anticonvulsants.⁶²

61. Rosenbaum, C., & Boyer, E. (2023). Dextromethorphan misuse and poisoning: Clinical features and diagnosis. *UpToDate*. www.uptodate.com
62. Lavonas, E. J., Akpunonu, P. D., Arens, A. M., Babu, K. M., Cao, D., Hoffman, R. S., Hoyte, C. O., Mazer-Amirshahi, M. E., Stolbach, A., St-Onge, M., Thompson, T. M., Wang, G. S., Hoover, A. V., & Drennan, I. R. (2023). 2023 American Heart Association focused update on the management of patients with cardiac arrest or life-threatening toxicity due to poisoning: An update to the American Heart Association guidelines for cardiopulmonary resuscitation and emergency cardiovascular care. *Circulation*, 148(16), e149-e184. [doi:10.1161/CIR.0000000000001161](https://doi.org/10.1161/CIR.0000000000001161).

Stimulant Use and Intoxication

Stimulants include amphetamine-type substances, cocaine, and crack. Stimulants cause the release of dopamine in the brain and are highly addictive because the flood of dopamine in the brain's reward circuit strongly reinforces drug-taking behaviors. With continued drug use, the reward circuit adapts and becomes less sensitive to the drug. As a result, people take stronger and more frequent doses in an attempt to feel the same high and to obtain relief from withdrawal symptoms. Because the high from stimulants starts and fades quickly, people often take repeated doses in a form of bingeing, often giving up food and sleep while continuing to take the drug every few hours for several days. Both the use and withdrawal from amphetamines can cause psychosis with symptoms of hallucinations and paranoia.⁶³

Approximately 2 million Americans used methamphetamine in the past year.⁶⁴ Methamphetamine comes in many forms and can be ingested by smoking, swallowing a pill, snorting, or injecting the powder that has been dissolved in water or alcohol. Methamphetamine can be easily made in small clandestine laboratories with relatively inexpensive over-the-counter ingredients such as pseudoephedrine, a common ingredient in cold medications. To curb this illegal production, federal law requires pharmacies take steps to limit sales and obtain photo identification from purchasers. Methamphetamine production also involves a number of other very dangerous chemicals. Toxic effects from these chemicals can remain in the environment long after the lab has been shut down, causing a wide range of

63. National Institute on Drug Abuse, & National Institutes of Health. (2024). *Methamphetamine*. <https://nida.nih.gov/research-topics/methamphetamine.gov/publications/drugfacts/methamphetamine>

64. National Institute on Drug Abuse, & National Institutes of Health. (2024). *Methamphetamine*. <https://nida.nih.gov/research-topics/methamphetamine.gov/publications/drugfacts/methamphetamine>

health problems for people living in the area. These chemicals can also result in deadly lab explosions and house fires.⁶⁵

Long-term use of methamphetamine has many negative consequences, including extreme weight loss, severe dental problems, intense itching leading to skin sores from scratching, involuntary movements (dyskinesia), anxiety, memory loss, and violent behavior.⁶⁶

Cocaine is another powerfully addictive stimulant drug made from the leaves of the coca plant native to South America. It is estimated that 5.5 million people aged 12 or older have used cocaine, including about 778,000 users of crack.⁶⁷ Users may snort cocaine powder through the nose, rub it into their gums, or dissolve the powder and inject it into the bloodstream. Cocaine that has been processed to make a rock crystal is called “crack.” The crystal is heated (making crackling sounds) to produce vapors that are inhaled into the lungs. In the short-term, cocaine use can result in increased blood pressure, restlessness, and irritability. In the long-term, severe medical complications of cocaine use include heart attacks and seizures.⁶⁸

65. National Institute on Drug Abuse, & National Institutes of Health. (2024). *Methamphetamine*. <https://nida.nih.gov/research-topics/methamphetamine>

66. National Institute on Drug Abuse, & National Institutes of Health. (2024). *Methamphetamine*. <https://nida.nih.gov/research-topics/methamphetamine>

67. National Institute on Drug Abuse, & National Institutes of Health. (2024). *Cocaine*. <https://nida.nih.gov/research-topics/cocaine>

68. National Institute on Drug Abuse, & National Institutes of Health. (2024). *Cocaine*. <https://nida.nih.gov/research-topics/cocaine>

Stimulant intoxication causes problematic behavioral or psychological changes such as euphoria or blunted affect; changes in sociability; hypervigilance; interpersonal sensitivity; anxiety, tension, or anger; and impaired judgment. These are some symptoms of stimulant intoxication⁶⁹:

- Tachycardia or bradycardia
- Pupillary dilation
- Elevated or decreased blood pressure
- Perspiration or chills
- Nausea or vomiting
- Weight loss
- Psychomotor agitation or retardation
- Muscular weakness, respiratory depression, chest pain or cardiac arrhythmias
- Confusion, seizures, dyskinesia (involuntary, erratic, writhing movements of the face, arms, legs, or trunk), dystonia (involuntary muscle contractions that result in slow repetitive movements), or coma

MEDICAL TREATMENT FOR STIMULANT INTOXICATION

It is important for nurses to be aware that individuals with acute stimulant intoxication may, without provocation, develop severe agitation with extreme violence and place themselves, family members, medical staff, and other clients at risk of major injury. Control of agitation and hyperthermia (body temperature over 41 degrees Celsius) receive top priority for treatment with the following interventions⁷⁰:

- Intravenous benzodiazepines are administered immediately for chemical

69. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

70. Boyer, E. W., & Hernon, C. (2024). Methamphetamine: Acute intoxication. *UpToDate*. www.uptodate.com

sedation of severely agitated individuals.

- Physical restraints should be avoided because clients who physically struggle against restraints undergo isometric muscle contractions that are associated with lactic acidosis, hyperthermia, sudden cardiac collapse, and death.
- Airway management with endotracheal intubation and mechanical ventilation may be required.
- Aggressive cooling is achieved through sedation, fluid resuscitation, external cooling blankets, or evaporative cooling techniques. Antipyretics are not used because the increased body temperature is caused by muscular activity, not an alteration in the hypothalamic temperature set point.

MEDICAL TREATMENT FOR STIMULANT OVERDOSE

Medical treatment for stimulant overdose requires rapid, comprehensive interventions due to the risk of life-threatening complications such as seizures, arrhythmias, and hyperthermia. Immediate goals include sedation, cardiovascular stabilization, airway protection, and cooling. Intravenous benzodiazepines remain the first-line treatment to manage agitation and prevent seizures. In cases of severe overdose, intensive care support may be necessary, including endotracheal intubation, mechanical ventilation, and advanced cardiac life support. Continuous cardiac monitoring is critical due to the high risk of arrhythmias and myocardial infarction. Hyperthermia is treated aggressively with external cooling methods, intravenous fluids, and sedation; antipyretics are ineffective and not indicated. Rhabdomyolysis, acute kidney injury, and multi-organ failure may develop, requiring supportive care such as IV hydration or renal replacement therapy. Early recognition and escalation to intensive care are essential to improve outcomes.⁷¹

71. Boyer, E. W., & Hernon, C. (2024). Methamphetamine: Acute intoxication. *UpToDate*. www.uptodate.com

- ▶ Read [DrugFacts](#) by the National Institute on Drug Abuse for more information about substances, intoxication, and overdose.

Inhalant Use and Intoxication

In 2020, 2.4 million (0.9 percent) of people aged 12 or older in America used inhalants. Unlike other illicit drugs, the percentage of inhalant use was highest among adolescents aged 12 to 17.⁷² Inhalants are various products easily bought or found in the home, such as spray paints, markers, glue, gasoline, and cleaning fluids. People who use inhalants breathe in the fumes through their nose or mouth, usually by sniffing, snorting, bagging, or huffing. Although the high that inhalants produce usually lasts just a few minutes, people often try to make it last by continuing to inhale again and again over several hours.⁷³

Prescription medications can also be misused as inhalants. For example, amyl nitrate is a prescription medication administered via inhalation to relieve chest pain. However, it is misused by individuals to cause a high. It is referred to by the street drug name as “poppers.”

Inhalant intoxication causes problematic behavioral or psychological changes

72. National Institute on Drug Abuse, & National Institutes of Health. (2024). *Inhalants*. <https://nida.nih.gov/research-topics/inhalants>

73. National Institute on Drug Abuse, & National Institutes of Health. (2024). *Inhalants*. <https://nida.nih.gov/research-topics/inhalants>

such as belligerence, assaultiveness, apathy, and impaired judgment. Inhalant intoxication includes these symptoms⁷⁴:

- Dizziness
- Nystagmus
- Incoordination
- Slurred speech
- Unsteady gait
- Lethargy
- Depressed reflexes
- Psychomotor retardation
- Tremor
- Generalized muscle weakness
- Blurred or double vision
- Stupor or coma
- Euphoria

Long-term effects of inhalant use may include liver and kidney damage, hearing loss, bone marrow damage, loss of coordination and limb spasms (from nerve damage), delayed behavioral development (from brain problems), and brain damage (from cut-off oxygen flow to the brain).⁷⁵

Acute intoxication with inhalants can cause life-threatening seizures and coma. Many solvents and aerosol sprays are highly concentrated with many other active ingredients; sniffing these products can cause the heart to stop

74. American Psychiatric Association. (2022). *Desk reference to the diagnostic criteria from DSM-5-TR* (5th ed.). American Psychiatric Association Publishing.

75. National Institute on Drug Abuse, & National Institutes of Health. (2024). *Inhalants*. <https://nida.nih.gov/research-topics/inhalants>

within minutes. This condition, known as sudden sniffing death, can happen to otherwise healthy young people the first time they use an inhalant.⁷⁶

MEDICAL TREATMENT FOR INHALANT INTOXICATION

Treatment consists of maintaining cardiorespiratory function with 100 percent oxygen administration by rebreather mask and implementation of Pediatric Advanced Life Support (PALS) protocols that may require endotracheal intubation and mechanical ventilation.⁷⁷

MEDICAL TREATMENT FOR INHALANT OVERDOSE

Treatment of inhalant overdose focuses on immediate stabilization and supportive care. Clients should be removed from the exposure source and placed in a well-ventilated area or given supplemental oxygen to address hypoxia. Continuous monitoring of vital signs, cardiac rhythm, and respiratory status is essential due to the risk of sudden sniffing death syndrome, which results from cardiac arrhythmias. In cases of respiratory depression or loss of consciousness, airway management and mechanical ventilation may be necessary. Seizures, if present, are treated with intravenous benzodiazepines. Because some inhalants can cause chemical pneumonitis, metabolic acidosis, or hepatic and renal injury, further care may include fluid resuscitation, correction of acid-base imbalances, and monitoring for organ dysfunction. Admission to intensive care may be required for clients with severe symptoms or multi-organ involvement.

76. National Institute on Drug Abuse, & National Institutes of Health. (2024). *Inhalants*. <https://nida.nih.gov/research-topics/inhalants>

77. Boyer, E. W., & Hernon, C. (2024). Methamphetamine: Acute intoxication. *UpToDate*. www.uptodate.com

14.3 Withdrawal Management/Detoxification

Nurses working in hospital settings or emergency departments commonly provide care for clients receiving withdrawal treatment for alcohol, opioids, or other substances. Furthermore, clients frequently underreport alcohol and substance use, so nurses must be aware of signs of withdrawal in clients receiving medical care for other issues and notify the health care provider.¹

Withdrawal management, also called detoxification, includes interventions aimed at managing the physical and emotional symptoms that occur after a person suddenly stops using a psychoactive substance. Withdrawal symptoms vary in intensity and duration based on the substance(s) used, the duration and amount of use, and the overall health of the individual. Some substances, such as opioids, sedatives, and tranquilizers, produce significant physical withdrawal effects, especially if they have been used in combination with heavy alcohol use. Rapid or unmanaged cessation from these substances can result in a longer than expected course of withdrawal with seizures and other health complications.

Assessment and treatment of withdrawal symptoms will be further discussed in the following sections.

Alcohol Withdrawal

The prevalence of alcohol use disorder is estimated to be as high as 32 percent among hospitalized clients. Approximately half of clients with alcohol use disorder experience alcohol withdrawal when they reduce or stop drinking, with as many as 20 percent experiencing serious manifestations such as hallucinations, seizures, and delirium tremens.² Severe alcohol

1. Sellers, E. M. (n.d.). *CIWA-AR for alcohol withdrawal*. MDCalc. <https://www.mdcalc.com/ciwa-ar-alcohol-withdrawal#why-use>

2. Pace, C. (2025). Alcohol withdrawal: Epidemiology, clinical manifestations, course, assessment, and diagnosis. *UpToDate*. www.uptodate.com

withdrawal is considered a medical emergency that is best managed in an intensive care unit.

Symptoms of early or mild alcohol withdrawal include anxiety, minor agitation, restlessness, insomnia, tremor, diaphoresis, palpitations, headache, and alcohol craving. Clients often experience loss of appetite, nausea, vomiting, and diarrhea. Their risk for falls often increases when they try to go unassisted to the bathroom with these gastrointestinal symptoms. Physical signs include sinus tachycardia, systolic hypertension, hyperactive reflexes, and tremor. Without treatment, symptoms of mild alcohol withdrawal generally begin within 6 to 24 hours after the last drink and resolve within one to two days.³

Some clients develop moderate to severe withdrawal symptoms that can last up to six days, such as withdrawal hallucinations, seizures, or delirium tremens:

- Hallucinations typically occur within 12 to 24 hours after the last drink. They are typically visual and commonly involve seeing insects or animals in the room, although auditory and tactile phenomena may also occur..⁴
- Alcohol withdrawal-related seizures can occur within 6 to 48 hours after the last drink. Risk factors for seizures include concurrent withdrawal from benzodiazepines or other sedative-hypnotic drugs..⁵
- **Delirium tremens (DTs)** is a rapid-onset, fluctuating disturbance of attention and cognition that is sometimes associated with hallucinations.

3. Pace, C. (2025). Alcohol withdrawal: Epidemiology, clinical manifestations, course, assessment, and diagnosis. *UpToDate*. www.uptodate.com

4. Pace, C. (2025). Alcohol withdrawal: Epidemiology, clinical manifestations, course, assessment, and diagnosis. *UpToDate*. www.uptodate.com

5. Pace, C. (2025). Alcohol withdrawal: Epidemiology, clinical manifestations, course, assessment, and diagnosis. *UpToDate*. www.uptodate.com

In its most severe manifestation, DTs are accompanied by agitation and signs of extreme autonomic hyperactivity, including fever, severe tachycardia, hypertension, and drenching sweats. DTs typically begin between 72 and 96 hours after the client's last drink. Mortality rates from withdrawal delirium have been historically as high as 20 percent, but with appropriate medical management, the mortality rate is between 1 and 4 percent. Death is attributed to cardiovascular complications, hyperthermia, aspiration, and severe fluid and electrolyte disorders..⁶

Clinical Institute Withdrawal Assessment for Alcohol Scale (CIWA-Ar)

The Clinical Institute Withdrawal Assessment for Alcohol Scale (CIWA-Ar) is the most widely used scale to determine the need for medically supervised withdrawal management. It is used in a wide variety of settings, including outpatient, emergency, psychiatric, general medical-surgical, and intensive care units when there is a clinical concern regarding a client's alcohol withdrawal.

The CIWA-Ar scale is typically utilized in association with a protocol containing medications to guide symptom-triggered treatment. Clients with an alcohol use disorder who have a CIWA-Ar score of less than 10 do not typically require medical management.⁷ Treatment score may vary depending upon agency protocol.

There are ten questions on the CIWA-Ar related to nausea/vomiting, tremor, paroxysmal sweats, anxiety, agitation, tactile disturbances, auditory disturbances, visual disturbances, headache, and level of orientation. The

6. Pace, C. (2025). Alcohol withdrawal: Epidemiology, clinical manifestations, course, assessment, and diagnosis. *UpToDate*. www.uptodate.com

7. Pace, C. (2025). Alcohol withdrawal: Epidemiology, clinical manifestations, course, assessment, and diagnosis. *UpToDate*. www.uptodate.com

questions are rated from 0 to 7, except for orientation that is rated from 0 to 4. View the full CIWA-Ar scale in the following box.

▶ View the [CIWA-Ar](#) on the MDCalc medical reference website.

View a supplementary YouTube video⁸ of a physician
▶ performing a CIWA assessments on a simulated client: [A
CIWA-Ar assessment](#)

Treatment of Alcohol Withdrawal

Benzodiazepines are used to treat the psychomotor agitation associated with alcohol withdrawal and prevent progression from minor symptoms to severe symptoms of seizures, hallucinations, or delirium tremens. Diazepam (Valium), lorazepam (Ativan), and chlordiazepoxide (Librium) are used most frequently to treat or prevent alcohol withdrawal symptoms.⁹ Precedex (dexmedetomidine), a selective alpha-2 adrenergic agonist, is increasingly being utilized as an adjunctive treatment for alcohol withdrawal, particularly in severe cases such as alcohol withdrawal delirium or when traditional

8. META:PHI Ontario. (2023, November 22). *A CIWA-Ar assessment* [Video]. YouTube. All rights reserved. https://www.youtube.com/watch?v=Go_CJS7dhVI

9. Hoffman, R. & Weinhouse, G. (2025). Management of moderate and severe alcohol withdrawal symptoms. *UpToDate*. www.uptodate.com

therapies like benzodiazepines are insufficient. Its sedative and anxiolytic properties help manage agitation and autonomic hyperactivity without causing significant respiratory depression, making it a valuable option in intensive care settings. By reducing sympathetic outflow, Precedex can help stabilize vital signs, improve comfort, and decrease the need for high doses of other sedatives. However, its use should be carefully monitored due to potential side effects such as bradycardia and hypotension.¹⁰

- ▶ Review information about benzodiazepines in the “[Antianxiety Medications](#)” section of the “Psychotropic Medications” chapter.

Anticonvulsants may be used concurrently or instead of benzodiazepines. Anticonvulsants decrease the probability of withdrawal seizures.

- ▶ Review information about anticonvulsants in the “[Treatments for Bipolar Disorders](#)” section of the “Bipolar Disorders” chapter.

Chronic alcohol use is associated with depletion of thiamine and magnesium. Clients receiving alcohol withdrawal treatment typically receive intravenous thiamine, along with dextrose, to prevent Wernicke’s encephalopathy. Wernicke’s encephalopathy is an acute, life-threatening neurological condition characterized by nystagmus, ataxia, and confusion caused by

10. Yavarovich, E. R., Bintvihok, M., & McCarty, J. C. (2019). Association between dexmedetomidine use for the treatment of alcohol withdrawal syndrome and intensive care unit length of stay. *Journal of Intensive Care*, 7(49)
<https://doi.org/10.1186/s40560-019-0405-1>

thiamine (B1) deficiency associated with alcohol use disorder.¹¹ If untreated, Wernicke's encephalopathy can progress to Korsakoff's syndrome, a chronic, irreversible memory disorder resulting from thiamine deficiency.¹² Treatment of other electrolyte deficiencies may be included during alcohol withdrawal treatment and medications may be given via the oral route if tolerated by the client.

Opioid Withdrawal

Medically supervised opioid withdrawal, also known as detoxification, involves administering medication to reduce the severity of withdrawal symptoms that occur when an opioid-dependent client stops using opioids. However, supervised withdrawal alone does not generally result in sustained abstinence from opioids, nor does it address reasons the client became dependent on opioids.¹³

Clients may undergo detoxification for several reasons¹⁴:

- Initiating the process to “get clean and stay clean” from opioids. Some clients may follow up with inpatient or outpatient treatment after

11. Vasan, S., & Kumar, A. (2023). *Wernicke encephalopathy*. StatPearls [Internet]. <https://www.ncbi.nlm.nih.gov/books/NBK470344/>

12. National Institute of Neurological Disorders and Stroke. (n.d). *Wernicke-Korsakoff syndrome*. [https://www.ninds.nih.gov/health-information/disorders/wernicke-korsakoff-syndrome#:~:text=Korsakoff%20syndrome%20\(also%20called%20Korsakoff's,t he%20brain%20involved%20with%20memory.](https://www.ninds.nih.gov/health-information/disorders/wernicke-korsakoff-syndrome#:~:text=Korsakoff%20syndrome%20(also%20called%20Korsakoff's,t he%20brain%20involved%20with%20memory.)

13. Sevarino, K. A. (2022). Medically supervised opioid withdrawal during treatment for addiction. *UpToDate*. www.uptodate.com

14. Sevarino, K. A. (2022). Medically supervised opioid withdrawal during treatment for addiction. *UpToDate*. www.uptodate.com

completing the detoxification process.

- Treating withdrawal symptoms when a client dependent on opioids or heroin becomes hospitalized and lacks access to the misused substance.
- Beginning the first step in treating opioid use disorder and transitioning to medication-assisted treatment like methadone or suboxone treatment.
- Establishing an abstinent state without withdrawal symptoms required for the client's setting or status (e.g., incarceration, probation, or a drug-free residential program).

Clinical Opiate Withdrawal Scale

The Clinical Opiate Withdrawal Scale (COWS) is used in both inpatient and outpatient settings for the monitoring of withdrawal symptoms during opioid detoxification. It can be serially administered to track changes in the severity of withdrawal symptoms over time or in response to treatment.¹⁵

Symptoms of opioid withdrawal include drug craving, anxiety, restlessness, gastrointestinal distress, diaphoresis, and tachycardia. COWS rates the severity of 11 signs and symptoms of opioid withdrawal on a scale from 0 to 5, as described in the following box.

▶ View the [COWS](#) on the MedCalc medical reference website.

Treatment of Opioid Withdrawal

A calm, quiet environment with supportive and reassuring staff is instrumental for helping clients overcome most symptoms of acute opioid

15. Wesson, D. R. (n.d.). *COWS score for opiate withdrawal*. MDCalc.
<https://www.mdcalc.com/cows-score-opiate-withdrawal#why-use>

withdrawal and can decrease the need for pharmacologic interventions. Clients who have associated diarrhea, vomiting, or sweating should be monitored for dehydration and have fluid levels maintained with oral and/or intravenous fluids.¹⁶

Medications commonly used to treat opioid withdrawal symptoms include opioid agonists such as buprenorphine and naloxone, or methadone or alpha-2 adrenergic agonists such as clonidine. Other medications may be prescribed to treat specific symptoms.¹⁷

BUPRENORPHINE

Buprenorphine is an effective treatment for opioid withdrawal symptoms. A disadvantage of buprenorphine is it can worsen opioid withdrawal symptoms if not administered carefully. To avoid this situation, the client must be in a state of mild to moderate withdrawal before receiving their first dose of buprenorphine (i.e., have a COWS score greater than 10). The first dose of buprenorphine is typically 2 to 4 mg sublingually.¹⁸

Buprenorphine can cause respiratory depression. Common side effects include sedation, headache, nausea, constipation, and insomnia.¹⁹

16. Sevarino, K. A. (2023). Medically supervised opioid withdrawal during treatment for addiction. *UpToDate*. www.uptodate.com

17. Sevarino, K. A. (2023). Medically supervised opioid withdrawal during treatment for addiction. *UpToDate*. www.uptodate.com

18. Sevarino, K. A. (2023). Medically supervised opioid withdrawal during treatment for addiction. *UpToDate*. www.uptodate.com

19. Sevarino, K. A. (2023). Medically supervised opioid withdrawal during treatment for addiction. *UpToDate*. www.uptodate.com

BUPRENORPHINE/NALOXONE

The combination medication buprenorphine/naloxone (Suboxone) is commonly used for detoxification, as well as maintenance of abstinence from opioids. It may be used in outpatient settings as an opioid-blocker.²⁰

METHADONE

If buprenorphine is not available, methadone may be prescribed. Methadone is a long-acting, synthetic opioid that reduces opioid craving and withdrawal symptoms by blocking the effect of opioids. It is typically prescribed in one of two ways²¹:

- Substitution Therapy: Methadone is prescribed to replace the use of an opioid and then is gradually tapered to prevent severe withdrawal symptoms.
- Maintenance Therapy: It is prescribed long-term as one component of a comprehensive medication-assisted treatment plan for opioid use disorder. With counseling and other behavioral therapies, methadone helps individuals achieve and sustain recovery and lead active and meaningful lives.

In contrast to buprenorphine, methadone does not induce withdrawal symptoms when administered to a client with opioid in their system because it has an additive effect on opioids that are already present.

20. Sevarino, K. A. (2023). Medically supervised opioid withdrawal during treatment for addiction. *UpToDate*. www.uptodate.com

21. Substance Abuse and Mental Health Services Administration (SAMHSA). (2022). *Methadone*. <https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/methadone>

ALPHA-2 ADRENERGIC AGONISTS

Alpha-2 adrenergic agonists, such as clonidine, decrease many symptoms of opioid withdrawal and effectively relieve the autonomic symptoms of sweating, diarrhea, intestinal cramps, nausea, anxiety, and irritability. They are least effective for symptoms of myalgias, restlessness, insomnia, and craving.²²

Clonidine can be taken orally or administered via a clonidine patch and changed weekly. Relief from withdrawal symptoms typically occurs within 30 minutes after a dose. However, common side effects of hypotension and sedation limit the use of these drugs. Contraindications to Alpha-2 adrenergic agonists include hypotension, renal insufficiency, cardiac instability, pregnancy, and psychosis. Tricyclic antidepressants should be stopped three weeks prior to use.²³

SYMPTOM-SPECIFIC MEDICATIONS

Various medications are prescribed to provide targeted relief for symptoms of opioid withdrawal²⁴:

- Anxiety, irritability, restlessness: Diphenhydramine, hydroxyzine, lorazepam, and clonazepam
- Abdominal cramping: Dicyclomine
- Diarrhea: Bismuth and loperamide
- Nausea/vomiting: Ondansetron, prochlorperazine, and promethazine
- Insomnia: Trazodone, doxepin, mirtazapine, quetiapine, and zolpidem

22. Sevarino, K. A. (2023). Medically supervised opioid withdrawal during treatment for addiction. *UpToDate*. www.uptodate.com

23. Sevarino, K. A. (2023). Medically supervised opioid withdrawal during treatment for addiction. *UpToDate*. www.uptodate.com

24. Sevarino, K. A. (2023). Medically supervised opioid withdrawal during treatment for addiction. *UpToDate*. www.uptodate.com

- Muscle aches, joint pain, and headache: Ibuprofen, acetaminophen, ketorolac, and naproxen
- Muscle spasms and restless legs: Cyclobenzaprine, baclofen, diazepam, and methocarbamol

Warm baths, rehydration, and gentle stretching are also helpful for relieving muscle aches and cramps. Use of benzodiazepines and zolpidem is not recommended for clients receiving methadone or buprenorphine therapy unless they are under close medical supervision due to the risk of oversedation.²⁵

Benzodiazepine Withdrawal

Rapid recognition and treatment of benzodiazepine withdrawal is critical because it can be life threatening, especially in individuals who have been taking high doses or have used the medication for an extended period. The severity of withdrawal symptoms can range from mild to life threatening, depending on the duration of use, dosage, type of benzodiazepine, and presence of comorbid conditions. Initial symptoms may include tremors, anxiety, restlessness, and general malaise, often resembling rebound anxiety. As withdrawal progresses, more severe features can develop, including perceptual disturbances such as visual or auditory hallucinations, intense agitation, and depersonalization. In some cases, clients may experience psychosis with paranoid delusions or disorganized thinking.²⁶

Of particular concern is the risk of seizures, which may occur within one to five days of abrupt cessation or rapid tapering, especially in those with high dose or long term use. Seizures can be generalized and are potentially life threatening. Autonomic instability may present as tachycardia, hypertension,

25. Sevarino, K. A. (2023). Medically supervised opioid withdrawal during treatment for addiction. *UpToDate*. www.uptodate.com

26. Kang, A. (2024). Benzodiazepine withdrawal. *UpToDate*. www.uptodate.com

hyperthermia, and diaphoresis, further complicating the clinical picture and increasing the risk of morbidity and mortality if not promptly managed.

TREATMENT OF BENZODIAZEPINE WITHDRAWAL

Withdrawal from benzodiazepines is managed carefully due to the risk of severe symptoms, including anxiety, insomnia, irritability, tremors, perceptual disturbances, and in some cases, seizures or psychosis. Treatment typically involves substituting the short-acting benzodiazepine the individual has been using with a long-acting one, such as diazepam or clonazepam, which provides more stable blood levels and reduces the intensity of withdrawal symptoms. The medication is then gradually tapered over time, with the goal of minimizing withdrawal effects while avoiding excessive sedation or other complications. The tapering process can last several weeks to several months, depending on the dose, duration of use, and individual response. A slow and individualized taper is especially important for those who have been taking high doses or have used benzodiazepines over an extended period. Clinicians often recommend reducing the dose by no more than 10–25% every 1–2 weeks, adjusting based on the client's symptoms and tolerability.²⁷

Withdrawal Management and Stabilization

Withdrawal management is highly effective in preventing immediate and serious medical consequences associated with discontinuing substance use, but by itself, it is not an effective treatment for any substance use disorder. It is considered stabilization, meaning the client is assisted through a period of acute detoxification and withdrawal to be medically stable and substance-free. Stabilization often prepares the individual for treatment. It is considered a first step toward recovery, similar to the acute management of a diabetic coma as a first step toward managing the underlying illness of diabetes.

27. Kang, A. (2024). Benzodiazepine withdrawal. *UpToDate*. www.uptodate.com

Similarly, acute stabilization and withdrawal management are most effective when followed by evidence-based treatments and recovery services.²⁸

Unfortunately, many individuals who receive withdrawal management do not become engaged in treatment. Studies have found that half to three quarters of individuals with substance use disorders who receive withdrawal management services do not enter treatment. One of the most serious consequences when individuals do not begin continuing care after withdrawal management is overdose. Because withdrawal management reduces acquired tolerance, those who attempt to reuse their former substance in the same amount or frequency may overdose, especially those with opioid use disorders.²⁹

The remaining sections of this chapter will discuss substance abuse disorders and treatments, as well as prevention strategies.

28. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
29. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

14.4 Substance-Related and Other Addictive Disorders

Substance-Related Disorders

Prolonged, repeated misuse of substances can produce changes to the brain that can lead to a substance use disorder. According to the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, **substance use disorder (SUD)** is an illness caused by repeated misuse of substances such as alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics, anxiolytics, stimulants (amphetamines, cocaine, and other stimulants), and tobacco. All of these substances taken in excess have a common effect of directly activating the brain reward system and producing such an intense activation of the reward system that normal life activities may be neglected. Nonsubstance related disorders such as gambling disorder activate the same reward system in the brain.¹

Substance use disorders are diagnosed based on cognitive, behavioral, and psychological symptoms. See the *DSM-5* diagnostic criteria used for SUD in the following box. SUD can range from mild to severe and from temporary to chronic.²

DSM-5 Criteria for Substance Use Disorder

1. American Psychiatric Association. (2013). *Desk reference to the diagnostic criteria from DSM-5*.
2. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

SUD diagnosis requires the presence of two or more of the following criteria in a 12-month period³:

- The substance is often taken in larger amounts or over a longer period than intended.
- There is a persistent desire or unsuccessful efforts to cut down or control substance use.
- A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
- There is a craving, or a strong desire or urge, to use the substance.
- There is recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.
- There is continued substance use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by the effects of the substance.
- Important social, occupational, or recreational activities are given up or reduced because of substance use.
- There is recurrent substance use in situations in which it is physically hazardous.
- Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
- Tolerance develops to the substance, as defined by:
 - A need for markedly increased amounts of the

3. American Psychiatric Association. (2013). *Desk reference to the diagnostic criteria from DSM-5*.

substance to achieve intoxication or the desired effect.

- There is a markedly diminished effect with continued use of the same amount of the substance.
- Withdrawal symptoms occur when substance use is cut back or stopped following a period of prolonged use.

The disorder is classified as mild, moderate, or severe. Individuals exhibiting two or three symptoms are considered to have a “mild” disorder, four or five symptoms constitute a “moderate” disorder, and six or more symptoms are considered a “severe” substance use disorder.

Millions of Americans are diagnosed with SUD. See Figure 14.6⁴ for a graphic of the number of people aged 12 and older with a substance use disorder in 2020.

4. This image is a derivative of “People Aged 12 or Older with a Past Year Substance Use Disorder (SUD); 2020” table by [Substance Abuse and Mental Health Services Administration](#). (2021). Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health (HHS Publication No. PEP21-07-01-003, NSDUH Series H-56). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Used under Fair Use. Retrieved from <https://www.samhsa.gov/data/report/2020-nsduh-annual-national-report>

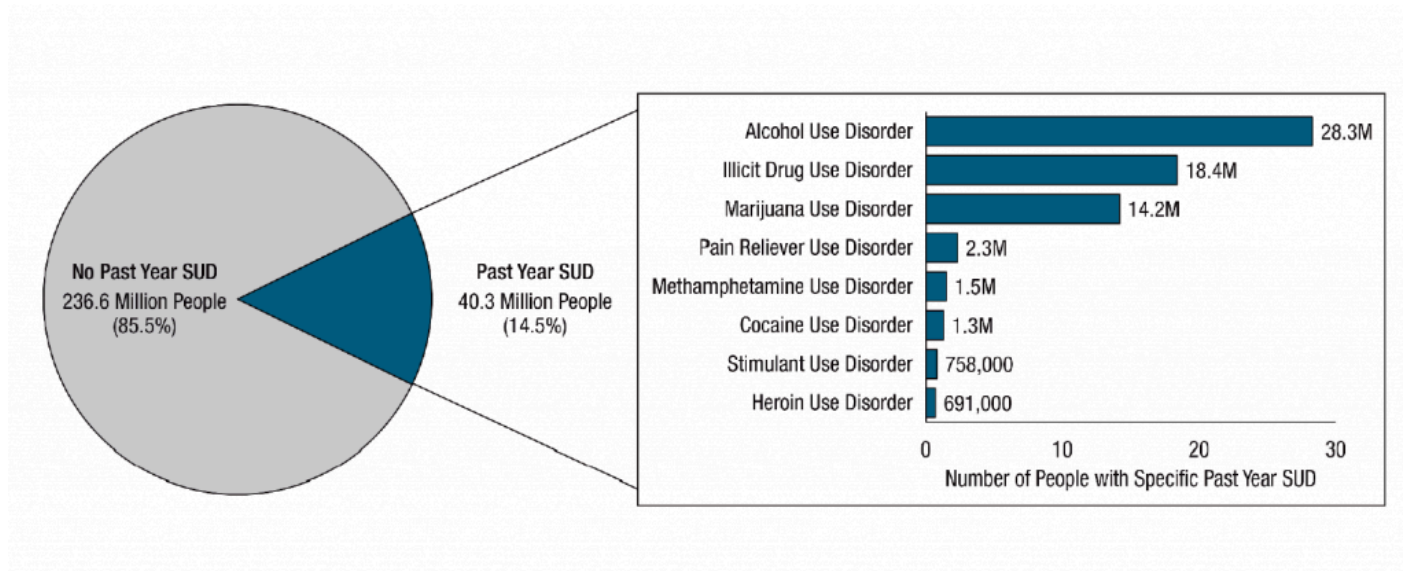


Figure 14.6 Number of People Aged 12 and Older With a Substance Use Disorder in 2020. Used under Fair Use.

SUD often develops gradually over time due to repeated misuse of a substance, causing changes in brain areas that control reward, stress, and executive functions like decision-making and self-control. Multiple factors influence whether a person will develop a substance use disorder such as the substance itself; the genetic vulnerability of the user; and the amount, frequency, and duration of the misuse.

Severe substance use disorders are commonly referred to as addictions.

Addiction is associated with compulsive or uncontrolled use of one or more substances. Addiction is a chronic illness that has the potential for both relapse and recovery. **Relapse** refers to the return to substance use after a significant period of abstinence. **Recovery** is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Although abstinence from substance misuse is a primary feature of a recovery lifestyle, it is not the only healthy feature.⁵ The chronic nature of addiction means that some individuals may

5. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

relapse after an attempt at abstinence, which can be a normal part of the recovery process. Relapse does not mean treatment failure. Relapse rates for substance use are similar to rates for adherence to therapies for other chronic medical illnesses. There are a variety of medications that can be prescribed to assist with relapse prevention.⁶

Individuals with severe substance use disorders can overcome their disorder with effective treatment and regain health and social function, referred to as **remission**. When positive changes and values become part of a voluntarily adopted lifestyle, this is referred to as “being in recovery.”⁷ Among the 29.2 million adults in 2020 who have ever had a substance use problem, 72.5 percent considered themselves to be in recovery.⁸

Many individuals seeking care in health care settings, such as primary care, obstetrics and gynecology, emergency departments, and medical-surgical units, have undiagnosed substance use disorders. Recognition and early treatment of substance use disorders can improve their health outcomes and reduce overall health care costs.⁹

6. National Institute on Drug Abuse. (2022). Drugs, brains, and behavior: The science of addiction treatment and recovery. <https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery>
7. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
8. Substance Abuse and Mental Health Services Administration. (2021). *Key substance use and mental health indicators in the United States: Results from the 2020 national survey on drug use and health*. Center for Behavioral Health Statistics and Quality, Substance Abuse, & Mental Health Services Administration. <https://www.samhsa.gov/data/>
9. Substance Abuse and Mental Health Services Administration, & Office of the

Substance Use Disorder in Nurses

Health care professionals are not immune to developing SUD. SUD is a chronic illness that can affect anyone regardless of age, occupation, economic circumstances, ethnic background, or gender. The National Council of State Boards of Nursing (NCSBN) created a brochure called *A Nurse's Guide to Substance Use Disorder in Nursing*. This brochure states that many nurses with substance use disorder (SUD) are unidentified, untreated, and may continue to practice when their impairment may endanger the lives of their clients. Because of the potential safety hazards to clients, it is a nurse's legal and ethical responsibility to report a colleague's suspected SUD to their manager or supervisor. It can be hard to differentiate between the subtle signs of SUD and stress-related behaviors, but three significant signs include behavioral changes, physical signs, and drug diversion.¹⁰

Behavioral changes include decreased job performance, absences from the unit for extended periods, frequent trips to the bathroom, arriving late or leaving early, and making an excessive number of mistakes including medication errors.¹¹

Physical signs include subtle changes in appearance that may escalate over time; increasing isolation from colleagues; inappropriate verbal or emotional responses; and diminished alertness, confusion, or memory lapses. Signs of

Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

10. NCSBSN. (2025). *A nurse's guide to substance use disorder in nursing* [Brochure]. <https://www.ncsbn.org/nursing-regulation/practice/substance-use-disorder/substance-use-in-nursing.page>
11. NCSBSN. (2025). *A nurse's guide to substance use disorder in nursing* [Brochure]. <https://www.ncsbn.org/nursing-regulation/practice/substance-use-disorder/substance-use-in-nursing.page>

diversion include frequent discrepancies in opioid counts, unusual amounts of opioid wastage, numerous corrections of medication records, frequent reports of ineffective pain relief from clients, offers to medicate coworkers' clients for pain, and altered verbal or phone medication orders.¹²

Drug diversion occurs when medication is redirected from its intended destination for personal use, sale, or distribution to others. It includes drug theft, use, or tampering (adulteration or substitution). Drug diversion is a felony that can result in a nurse's criminal prosecution and loss of license.¹³

The earlier that a nurse is diagnosed with SUD and treatment is initiated, the sooner that client safety is protected and the better the chances for the nurse to recover and return to work. In most states, a nurse diagnosed with a SUD enters a nondisciplinary program designed by the Board of Nursing for treatment and recovery services. When a colleague treated for an SUD returns to work, nurses should create a supportive environment that encourages their continued recovery.¹⁴

► View the NCSBN PDF pamphlet [A Nurse's Guide to Substance Use Disorder in Nursing](https://www.ncsbn.org/nursing-regulation/practice/substance-use-disorder/substance-use-in-nursing.page).

12. NCSBSN. (2025). *A nurse's guide to substance use disorder in nursing* [Brochure]. <https://www.ncsbn.org/nursing-regulation/practice/substance-use-disorder/substance-use-in-nursing.page>
13. Nyhus, J. (2021). Drug diversion in healthcare. *American Nurse*. <https://www.myamericannurse.com/drug-diversion-in-healthcare/>
14. NCSBSN. (2025). *A nurse's guide to substance use disorder in nursing* [Brochure]. <https://www.ncsbn.org/nursing-regulation/practice/substance-use-disorder/substance-use-in-nursing.page>

Nonsubstance-Related Disorders

Nonsubstance-related disorders are excessive behaviors related to gambling, viewing pornography, compulsive sexual activity, Internet gaming, overeating, shopping, overexercising, and overusing technologies. These behaviors are thought to stimulate the same addiction centers of the brain as addictive substances. However, gambling disorder is the only nonsubstance use disorder with diagnostic criteria listed in the *DSM-5*. See the *DSM-5* criteria for the diagnosis of a gambling disorder in the following box.

***DSM-5* Criteria for Gambling Disorder¹⁵**

Gambling disorder is defined as persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as indicated by four or more of the following criteria in a 12-month period. Additionally, the gambling behavior is not better explained by a manic episode.

- Needs to gamble with increasing amounts of money to achieve the desired excitement
- Is restless or irritable when attempting to cut down or stop gambling
- Has made repeated unsuccessful efforts to control, cut back, or stop gambling
- Is often preoccupied with gambling (e.g., persistent thoughts of reliving past gambling experiences, planning the next venture, or thinking of ways to get money with which to gamble)

15. American Psychiatric Association. (2013). *Desk reference to the diagnostic criteria from DSM-5*.

- Often gambles when feeling distressed (e.g., helpless, guilty, anxious, or depressed)
- After losing money gambling, often returns another day to get even (otherwise known as “chasing one’s losses”)
- Lies to conceal the extent of involvement with gambling
- Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling
- Relies on others to provide money to relieve desperate financial situation caused by gambling

14.5 Neurobiology of Substance Use Disorders

Severe substance use disorders, also called addictions, were once considered a moral failing or character flaw but are now known to be chronic illnesses. Scientific evidence shows that addiction to substances is a chronic brain disease that has potential for relapse and recovery.¹

All addictive substances have powerful effects on the brain. These effects account for the euphoric or intensely pleasurable feelings that people experience during their initial use of alcohol or other substances. These feelings motivate people to use those substances again and again, despite the risks for significant harm. As individuals continue to misuse alcohol or other substances, progressive changes, called **neuroadaptations**, occur in the structure and function of the brain. These neuroadaptations drive the transition from controlled, occasional substance use to chronic misuse that can be difficult to control and can endure long after an individual stops using the substances. These changes can lead to the need for increased amounts of substances to achieve the same effect, referred to as tolerance. They may produce continued, periodic cravings for the substance that can lead to relapse. More than 60 percent of people treated for a substance use disorder experience relapse within the first year after they are discharged from treatment, and a person can remain at increased risk of relapse for many years.²

1. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
2. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

For many people, initial substance use involves an element of impulsivity (i.e., acting without foresight or regard for the consequences). For example, an adolescent may impulsively take a first drink, smoke a cigarette, experiment with marijuana, or succumb to peer pressure and try a party drug like Ecstasy. If the experience is pleasurable, this feeling positively reinforces the substance use, making the person more likely to take the substance again. Another person may take a substance to relieve negative feelings such as stress, anxiety, or depression. In this case, the temporary relief the substance brings from the negative feelings reinforces substance use, increasing the likelihood that the person will use again.³

Many other environmental and social stimuli can reinforce a behavior. For example, peer approval positively reinforces substance use for some people. Likewise, if drinking or using drugs with others provides a feeling of relief from social isolation, substance use is reinforced.⁴

Eventually, in the absence of the substance, a person may experience negative emotions such as stress, anxiety, or depression or the individual may feel physically ill. This is called withdrawal, which often leads the person to use the substance again to relieve the withdrawal symptoms. As use becomes an ingrained behavior, impulsivity shifts to compulsivity, and the primary drivers of repeated substance use shift from positive reinforcement (feeling pleasure) to negative reinforcement (feeling relief) as the person seeks to stop the negative feelings and physical illness that accompany withdrawal. Eventually,

3. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
4. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

the person begins taking the substance not to get “high,” but rather to escape the “low” feelings from withdrawal. Compulsive substance seeking is a key characteristic of addiction, as well as loss of control over use. Compulsivity helps to explain why many people with addiction experience relapses after abstinence.⁵

Three regions of the brain are the key components in the development and persistence of substance use disorders: the basal ganglia, the extended amygdala, and the prefrontal cortex:

- The basal ganglia controls the rewarding, pleasurable effects of substance use and is responsible for the formation of habitual substance taking. Two subregions of the basal ganglia are particularly important in substance use disorders:
 - The nucleus accumbens, involved in motivation and the experience of reward.
 - The dorsal striatum, involved in forming habits and other routine behaviors.
- The extended amygdala is involved in the stress response and the feelings of unease, anxiety, and irritability that typically accompany substance withdrawal.
- The prefrontal cortex is involved in executive function (e.g., the ability to organize thoughts and activities, prioritize tasks, manage time, and make decisions), including exerting control over substance use.

These changes in the brain persist long after substance use stops and are associated with a high incidence of relapse with substance use disorders.

5. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

Risk Factors

Many factors influence the development of substance use disorders, including developmental, environmental, social, and genetic factors, and co-occurring mental health disorders. Other conditions called protective factors protect people from developing a substance use disorder or addiction. Examples of protective factors include positive self-image, self-control, and social competence. The relative influence of these factors varies across individuals and the life span.

Whether an individual ever uses alcohol or another substance and whether that initial use progresses to a substance use disorder of any severity depends on a number of factors including the following⁶:

- A person's genetic makeup and biological factors
- The age when substance use begins
- Psychological factors related to a person's unique history and personality
- Environmental factors, such as the availability of drugs, family and peer dynamics, financial resources, cultural norms, exposure to stress, and access to social support

Early Life Experiences

The experiences a person has early in childhood and in adolescence can set the stage for substance use and sometimes escalate to substance use disorder. Early life stressors (referred to as adverse childhood experiences) include physical, emotional, and sexual abuse; neglect; household instability

6. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

(such as parental substance use and conflict, mental illness, or incarceration of household members); and poverty.⁷

- ▶ Review information on adverse childhood experiences in the “[Mental Health and Mental Illness](#)” section of Chapter 1.

Adolescence is a critical vulnerable period for substance misuse and the development of substance use disorders because a characteristic of this developmental period is risk taking and experimentation. For some young people, this includes trying alcohol, marijuana, or other drugs. Additionally, the brain undergoes significant changes during this life stage, making it particularly vulnerable to substance exposure. For example, the frontal cortex, a region in the front part of the brain that includes the prefrontal cortex, does not fully develop until the early to mid-20s. Research shows that heavy drinking and drug use during adolescence affects development of this critical area of the brain.⁸

Approximately 74 percent of 18- to 30-year-olds admitted to treatment programs began using substances at the age of 17 or younger. Individuals who start using substances during adolescence often experience more chronic and intensive use, and they are at greater risk of developing a

7. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
8. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

substance use disorder compared with those who begin use at an older age. In other words, the earlier the exposure, the greater the risk.⁹

Genetic and Molecular Factors

Genetic factors are thought to account for 40 to 70 percent of individual differences in risk for addiction. Although multiple genes are likely involved in the development of addiction, only a few specific gene variants have been identified that either predispose to or protect against addiction. Some of these variants have been associated with the metabolism of alcohol and nicotine, while others involve receptors and other proteins associated with key neurotransmitters and molecules involved in all parts of the addiction cycle. Genes involved in strengthening the connections between neurons and in forming drug memories have also been associated with addiction risk. Like other chronic health conditions, substance use disorders are influenced by the complex interplay between a person's genes and environment.¹⁰

Concurrent Mental Health Disorders

In 2020, 17 million adults (6.7%) had both a substance use disorder (SUD) and any mental health illness (AMI) as illustrated in Figure 14.7.¹¹ The relationship

9. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
10. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
11. Image is a derivative of "Past Year Substance Abuse Disorder (SUD) and Any Mental Illness (AMI): Among Adults Aged 18 or Older; 2020" table by [Substance Abuse and Mental Health Services Administration](#). (2021). Key

between SUDs and mental disorders is known to be bidirectional, meaning the presence of a mental health disorder may contribute to the development or exacerbation of an SUD, or an SUD may contribute to the development or exacerbation of a mental health disorder. The combined presence of SUDs and mental health disorders results in greater functional impairment; worse treatment outcomes; higher morbidity and mortality; increased treatment costs; and higher risk for homelessness, incarceration, and suicide.

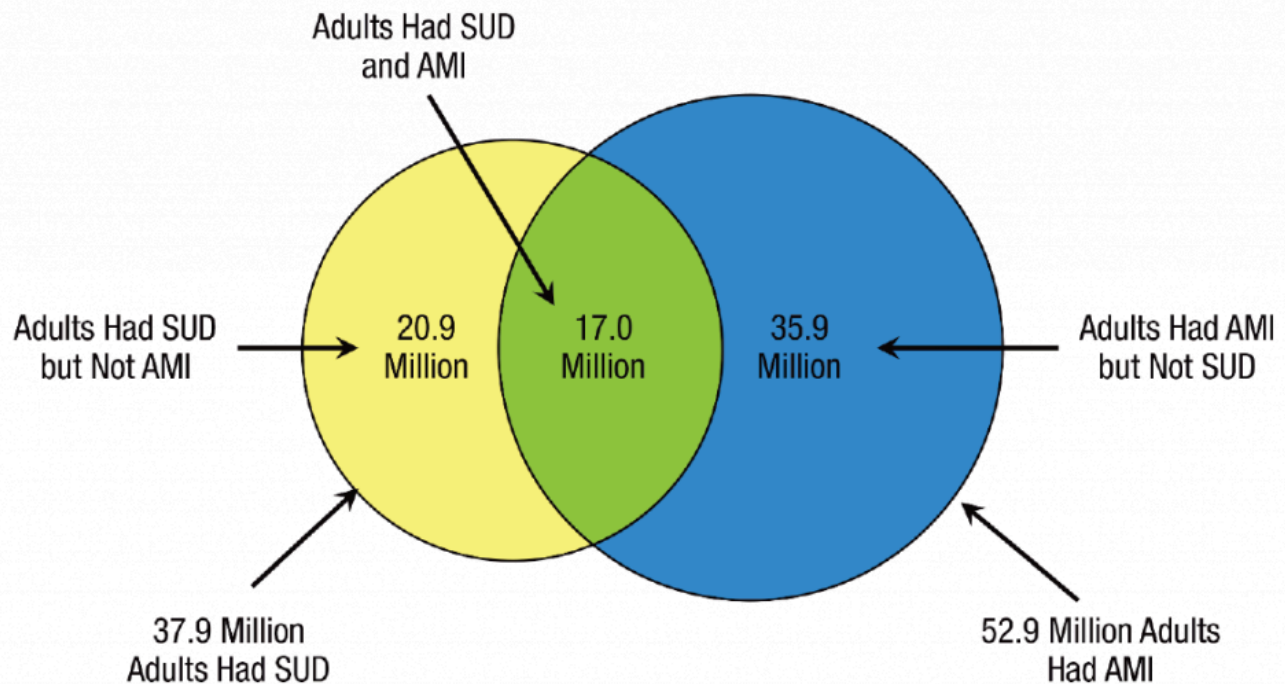


Figure 14.7 Concurrent Mental Illness (AMI) and Substance Use Disorder (SUD) in Adults in 2020. Used under Fair Use.

The reasons why substance use disorders and mental health disorders often occur together are not clear, but there are three possible explanations. One reason may be because certain substances may temporarily mask the

substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health (HHS Publication No. PEP21-07-01-003, NSDUH Series H-56). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Used under Fair Use. Retrieved from <https://www.samhsa.gov/data/report/2020-nsduh-annual-national-report> .

symptoms of mental health disorders (such as anxiety or depression). A second reason may be that certain substances trigger a mental health disorder that otherwise would not have developed. For example, research suggests that alcohol use increases risk for PTSD by altering the brain's ability to recover from traumatic experiences. A third possible reason is that both substance use disorders and mental health disorders are caused by overlapping factors, such as particular genes, neurobiology, or exposure to traumatic or stressful life experiences.¹²

Mental health disorders and substance use disorders have overlapping symptoms, making diagnosis and treatment planning challenging. For example, people who use methamphetamine for a long period of time may experience paranoia, hallucinations, and delusions that can be mistaken for symptoms of schizophrenia.¹³

Gender

Some groups of people are more vulnerable to substance misuse and substance use disorders. For example, biological males tend to drink more than biological females and are at higher risk for alcohol use disorder. However, biological females who use cocaine, opioids, or alcohol may progress from initial use to a substance use disorder faster than males. Compared with biological males, biological females also exhibit greater

12. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
13. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

withdrawal symptoms from some drugs such as nicotine and have higher levels of the stress hormone cortisol.¹⁴

Race and Ethnicity

Neurobiological factors contributing to differential rates of substance use disorders across racial and ethnic groups have been researched. A study using functional magnetic resonance imaging (fMRI) found that African American smokers showed greater activation of the prefrontal cortex upon exposure to smoking-related cues than did White smokers, an effect that may partly contribute to the lower smoking-cessation success rates among African Americans.¹⁵

Alcohol research on racial and ethnic groups has shown that approximately 36 percent of East Asians carry a gene variant that alters the rate of alcohol metabolism, causing a buildup of acetaldehyde, a toxic by-product that produces symptoms such as flushing, nausea, and rapid heartbeat. Although these effects may protect some individuals of East Asian descent from alcohol use disorder, those who drink despite the effects are at increased risk for esophageal and head and neck cancers.¹⁶

14. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
15. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
16. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

Individual, Family, and Community Level Risk Factors

An individual's risk factors for developing SUD include the following¹⁷:

- **Early initiation of substance use:** Engaging in alcohol or drug use at a young age
- **Early and persistent problem behavior:** Emotional distress, aggressiveness, and “difficult” temperaments in adolescents
- **Rebelliousness:** High tolerance for deviance and rebellious activities
- **Favorable attitudes toward substance use:** Positive feelings towards alcohol or drug use; low perception of risk
- **Peer substance use:** Friends and peers who engage in alcohol or drug use
- **Genetic predictors:** Genetic susceptibility to alcohol or drug use
- **Academic failure beginning in late elementary school:** Poor grades in school
- **Lack of commitment to school:** When a young person no longer considers the role of being a student as meaningful and rewarding or lacks investment or commitment to school

17. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

14.6 Addiction Cycle

Addiction Cycle

The addiction process involves a three-stage cycle that becomes more severe as a person continues to misuse substances, causing neuroadaptations in brain function that reduce a person's ability to control their substance use. Each stage is associated with one of the brain regions previously described (i.e., basal ganglia, extended amygdala, and prefrontal cortex). See Figure 14.8¹ for an image of the brain regions associated with the three stages of addiction. This three-stage model provides a useful way to understand the symptoms of addiction, the ways it can be prevented and treated, and the steps for recovery.²

These are the three stages of addiction:

- **Binge/Intoxication:** The stage at which an individual consumes an intoxicating substance and experiences its rewarding or pleasurable effects.
- **Withdrawal/Negative Affect:** The stage at which an individual experiences a negative emotional state in the absence of the substance.

1. Substance Abuse and Mental Health Services Administration (US); Office of the Surgeon General (US). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health* [Internet]. Washington (DC): US Department of Health and Human Services; 2016 Nov. Figure 2.3, The Three Stages of the Addiction Cycle and the Brain Regions Associated with Them. Used under Fair Use. Available from <https://www.ncbi.nlm.nih.gov/books/NBK424849/figure/ch2.f3/>
2. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

- **Preoccupation/Anticipation:** The stage at which one seeks substances again after a period of abstinence.

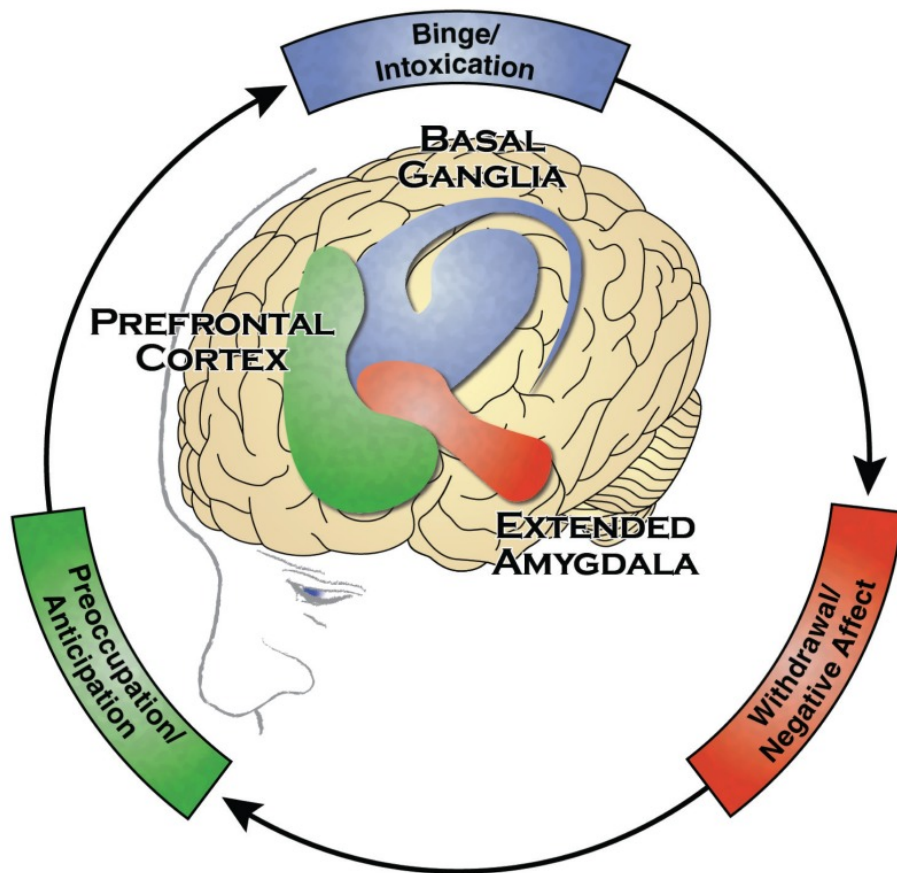


Figure 14.8 Brain Regions Associated With the Three Stages of Addiction. Used under Fair Use.

Binge/Intoxication: Basal Ganglia

All addictive substances produce feelings of pleasure. These “rewarding effects” positively reinforce their use and increase the likelihood of repeated use. The rewarding effects of substances involve activity in the nucleus accumbens, including activation of the brain’s dopamine and opioid signaling system. Studies show that antagonists, or inhibitors, of dopamine and opioid

receptors can block drug and alcohol-seeking behaviors.³ See Figure 14.9⁴ for an illustration of rewarding actions of addictive substances on the nucleus accumbens.

3. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
4. Substance Abuse and Mental Health Services Administration (US); Office of the Surgeon General (US). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health [Internet]. Washington (DC): US Department of Health and Human Services; 2016 Nov. Figure 2.5, Actions of Addictive Substances on the Brain. Used under Fair Use. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK424849/figure/ch2.f5/>

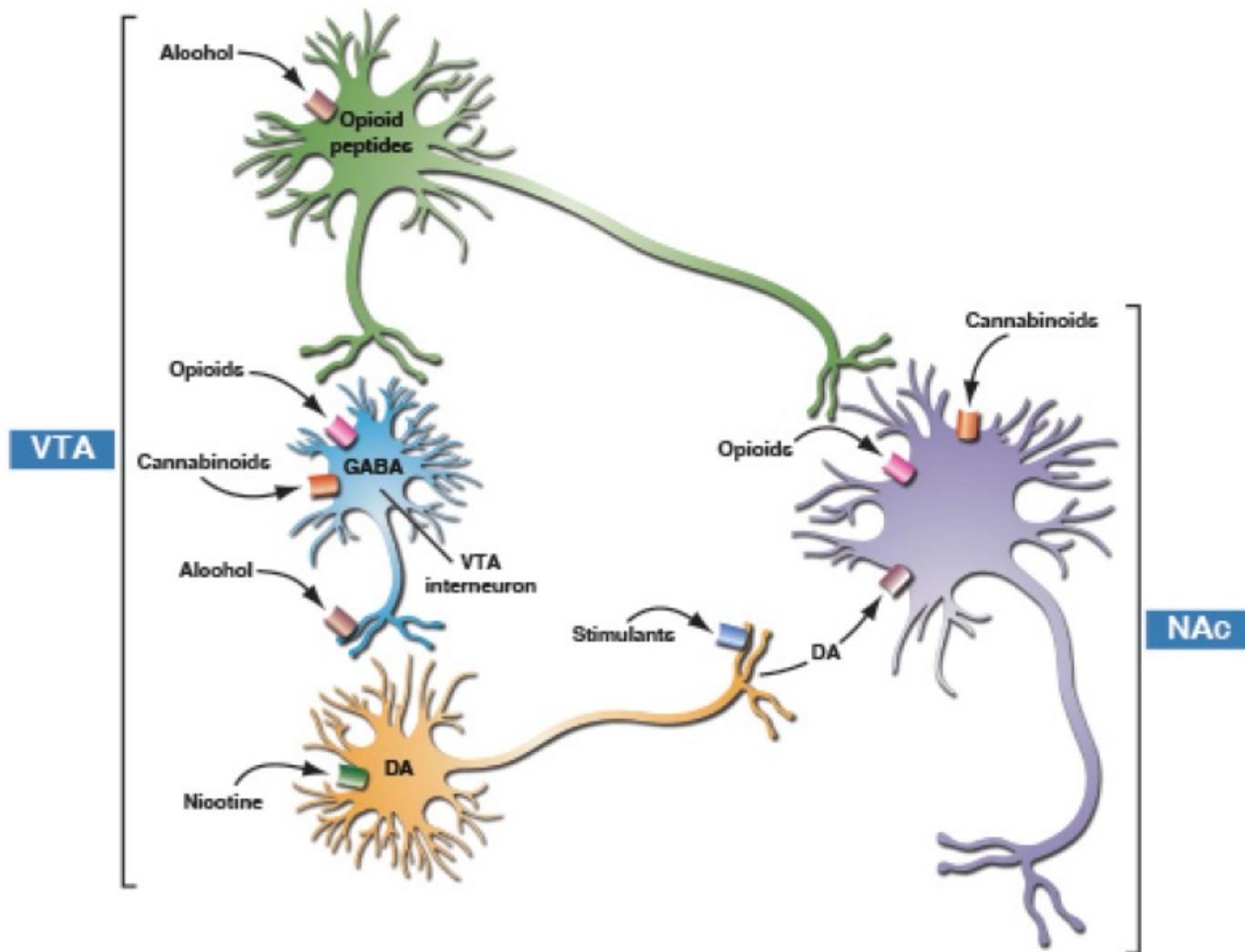


Figure 14.9 Rewarding Actions of Addictive Substances on the Nucleus Accumbens (NAc). Used under Fair Use.

Dopamine neurons (DA) are activated, either directly or indirectly, by all addictive substances, but particularly by stimulants and nicotine.⁵

The brain's opioid system includes naturally occurring opioid molecules (i.e., endorphins) and three types of opioid receptors (i.e., mu, delta, and kappa) and plays a key role in mediating the rewarding effects of opioids and alcohol.

5. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

Activation of the opioid system stimulates the nucleus accumbens (NAc) directly or indirectly through the GABA and dopamine (DA) system.⁶

Tetrahydrocannabinol (THC), the primary psychoactive component of marijuana, targets GABA neurons that stimulate the dopamine (DA) system, as well as directly stimulating the nucleus accumbens (NAc).⁷

Activation of the brain's reward system by alcohol and drugs not only generates the pleasurable feelings associated with those substances, but also ultimately triggers changes in the way a person responds to stimuli associated with the use of those substances. A person learns to associate the stimuli present while using a substance, including people, places, drug paraphernalia, and even internal states, such as mood, with the substance's rewarding effects. Over time, these stimuli can activate the dopamine system on their own and trigger powerful urges to take the substance. These "cravings" can persist even after the rewarding effects of the substance have diminished. As a result, exposure to people, places, or things previously associated with substance use can serve as triggers or cues that promote substance seeking and taking, even in people who are in recovery.⁸

6. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
7. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
8. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

Withdrawal/Negative Affect Stage: Amygdala

The withdrawal/negative affect stage of addiction follows the binge/intoxication stage, and, in turn, sets up future rounds of binge/intoxication. During this stage, a person who has been using alcohol or drugs experiences withdrawal symptoms, including negative emotions and symptoms of physical illness when they stop taking the substance. Symptoms of withdrawal may occur with all addictive substances, although they vary in intensity and duration depending on both the type of substance and the severity of use. The negative feelings associated with withdrawal are thought to come from two sources: diminished activation in the reward circuitry of the basal ganglia and activation of the brain's stress systems in the extended amygdala.⁹

When used long-term, all addictive substances cause dysfunction in the brain's dopamine reward system. For example, brain imaging studies in individuals with addictions show long-lasting decreases in dopamine receptors even after stopping substance abuse. See Figure 14.10¹⁰ for an image of brain imaging studies comparing an individual with cocaine addiction to someone without addiction. Decreases in the activity of the dopamine system have also been observed during withdrawal from stimulants, opioids, nicotine, and alcohol. Other studies also show that when an addicted person

9. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
10. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. Used under Fair Use. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

is given a stimulant, it causes a smaller release of dopamine than when the same dose is given to a person who is not addicted.¹¹

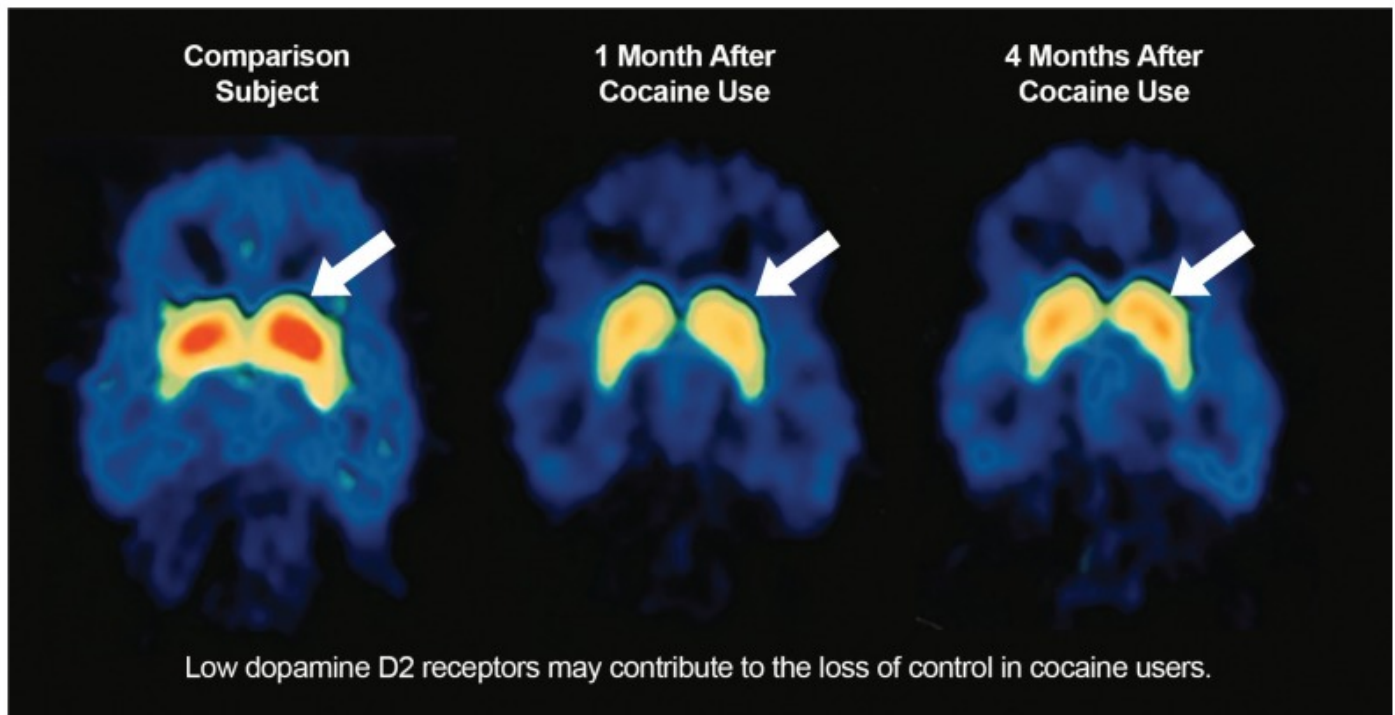


Figure 14.10 Decreased Dopamine Receptors in an Individual With a Cocaine Addiction. Used under Fair Use.

These findings suggest that people addicted to substances experience an overall reduction in the sensitivity of the brain's reward system (especially in the brain circuits involving dopamine), both to addictive substances and also to natural reinforcers, such as food and sex. This impairment explains why individuals who develop a substance abuse disorder often do not derive the same level of satisfaction or pleasure from once-pleasurable activities and may neglect eating. This loss of reward sensitivity may also account for the

11. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

compulsive escalation of substance use as addicted individuals attempt to regain the pleasurable feelings the reward system once provided.¹²

At the same time, a second process occurs during the withdrawal stage related to the activation of stress neurotransmitters in the extended amygdala. These stress neurotransmitters include corticotropin releasing factor (CRF), norepinephrine, and dynorphin. These neurotransmitters play a key role in the negative feelings associated with withdrawal and in stress-triggered substance use. When researchers used antagonists to block activation of addicted individuals' stress neurotransmitter systems, it reduced their substance intake in response to withdrawal and stress.¹³

Preoccupation/Anticipation Stage: Prefrontal Cortex

The preoccupation/anticipation stage of the addiction cycle is the stage in which a person may begin to seek to use substances again after a period of abstinence. In this stage, an addicted person becomes preoccupied with using substances again, referred to as craving. This stage of addiction involves the brain's prefrontal cortex, the region that controls executive function (e.g., the ability to organize thoughts and activities; prioritize tasks; manage time; make decisions; and regulate one's own actions, emotions, and impulses). Executive function is essential for a person to make appropriate choices about whether or not to use a substance and to override strong urges to use it, especially when experiencing triggers related to the substance (e.g., being at

12. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
13. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

a party where alcohol is served) or stressful experiences. People with alcohol, cocaine, or opioid use disorders show impairments in executive function, including disruption of decision-making and behavioral inhibition.¹⁴

14. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

14.7 Treatment of Substance Use Disorders

Research has shown that substance use disorders are similar in course, management, and outcome to other chronic illnesses, such as hypertension, diabetes, and asthma. It is possible to adopt the same type of chronic care management approach to the treatment of substance use disorders as is used to manage chronic physical illnesses. Remission of substance use disorders and even full recovery can be achieved if evidence-based care is provided for adequate periods of time by properly trained health care professionals and augmented with supportive monitoring, recovery support services, and social services.¹

There are a spectrum of effective strategies and services available to identify, treat, and manage substance use disorders. Research shows that the most effective way to help someone with a substance misuse problem who is at risk for developing a substance use disorder is to intervene early, before the condition can progress. Screening for substance misuse is increasingly being provided in general health care settings so that emerging problems can be detected and early intervention provided. The addition of services to address substance use problems and disorders in mainstream health care has extended the continuum of care and includes a range of effective, evidence-based medications; behavioral therapies; and supportive services. However, a number of barriers have limited the widespread adoption of these services, including common myths about addiction, lack of resources, insufficient training, and workforce shortages. This is particularly true for the treatment of individuals with co-occurring substance use and mental health disorders.²

1. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
2. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's*

There are several common myths about addiction that make it harder for people with substance use disorders to seek treatment to get well. Review these myths in the following box.

Common Myths About Addiction³

- Using drugs or alcohol is a choice, so if someone gets addicted, it's their fault.
 - **Reality:** Addiction is a consequence of many contributing factors, including genetics, neurobiology, adverse childhood effects (ACEs), trauma, and other influences.
- If someone just uses willpower, they should be able to stop using the substance.
 - **Reality:** For people who are genetically vulnerable to addiction, substance use can cause profound changes in the brain that hijack the reward pathway of the brain. Addictive substances flood the brain with neurotransmitters that signal pleasure. These changes create intense impulses to continue using the substances despite negative consequences of doing so.

report on alcohol, drugs, and health. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

3. Face It Together. (n.d.) *Common myths about addiction*. <https://www.wefaceittogether.org/learn/common-myths>

- Addiction affects certain types of people.
 - **Reality:** Addiction can affect anyone, no matter one's age, income, ethnicity, religion, family, or profession. Nationally, about one in eight people ages 12 and older are impacted.
- If someone has a stable job and family life, they can't be suffering from addiction.
 - **Reality:** Anyone is vulnerable to addiction. Many people hide the severity of their illness or don't get help because of stigma or shame.
- People have to become seriously ill before they can get well.
 - **Reality:** The longer a person waits to get help, the more changes happen to the brain, which can have deadly consequences like overdose. Studies show that people forced into treatment have an equal chance of successful recovery as people who initiate treatment on their own.
- Going to rehab will fix the problem.
 - **Reality:** Addiction is a chronic disease, similar to hypertension or diabetes, that can be controlled but not cured. Treatment is the first step towards wellness, but it is just the beginning. Staying well requires a lifelong commitment to managing the chronic disease.
- If someone relapses, they can never get better.

- **Reality:** Relapse is no more likely with addiction than other chronic illnesses like diabetes. Getting well involves changing deeply embedded behaviors that are significantly rewarded in the brain. Behavioral change takes time and effort, and setbacks can occur. A relapse can signal that the treatment approach or other supports need to change or that other treatment methods are needed. There is hope that people who experience a relapse will return to recovery.

Substance use disorder treatment is designed to help individuals stop or reduce harmful substance misuse, improve their health and social function, and manage their risk for relapse. For example, mild substance use disorders can be identified quickly in many medical settings and often respond to brief motivational interventions and/or supportive monitoring, referred to as guided self-change. In contrast, severe and chronic substance use disorders often require specialty substance use disorder treatment and continued post-treatment support to achieve full remission and recovery. To address the spectrum of problems associated with substance use disorders, a continuum of care is planned and implemented based on an individual's needs, including early intervention, treatment, and recovery support services.⁴

4. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

Early Intervention

Early intervention services can be provided in a variety of settings (e.g., school clinics, primary care offices, mental health clinics) to people who have substance misuse problems or mild substance use disorders. These services are usually provided when an individual presents for another medical condition or social service need and is not necessarily seeking treatment for a substance use disorder. The goals of early intervention are to reduce the harms associated with substance misuse, reduce risk behaviors before they lead to injury, improve health and social function, and prevent progression from misuse to a substance use disorder. Early intervention consists of providing education about risks of substance use, safe levels of alcohol and medication use, and strategies to quit substance use. Referral to treatment services is provided as needed.⁵

Populations Who Should Receive Early Intervention

Early intervention should be provided to children, adolescents, and adults who show signs of substance misuse or a mild substance use disorder. One group in need of early intervention is people who binge drink, particularly those aged 12 to 17, who are at higher risk for future substance use disorders because of their young age. Available research shows that brief, early interventions given by a respected care provider (such as a nurse, nurse educator, or physician) in the context of routine medical care can educate and motivate many individuals who are misusing substances to understand and acknowledge their risky behavior and reduce their substance use.⁶

5. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
6. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's*

Components of Early Intervention

One structured approach to delivering early intervention to people showing signs of substance misuse and/or early signs of a substance use disorder is through screening and brief intervention (SBI). Research has shown that several methods of SBI are effective in decreasing substance misuse for a variety of populations in a variety of health care settings.

SCREENING

Regardless of the substance, the first step of early intervention is using a screening tool to identify behaviors that put the individual at risk for harm or for developing a substance use disorder. Positive screening results should be followed by brief educational sessions tailored to the specific problems and interests of the individual. It should be delivered in a nonjudgmental manner, emphasizing both the importance of reducing substance use and the individual's ability to accomplish this goal. Follow-up evaluation should assess whether the screening and the brief intervention were effective in reducing the substance misuse or if formal treatment is required.⁷

Ideally, substance misuse screening should occur for all individuals who present to health care settings, including primary care, urgent care, mental health care, and emergency departments. Several validated screening instruments have been developed to help nonspecialty providers identify individuals who may have, or be at risk for, a substance use disorder. An example of an evidence-based screening tool is the Alcohol Use Disorders

report on alcohol, drugs, and health. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

7. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

Identification Test (AUDIT).⁸ Based on a World Health Organization study, the AUDIT has become the world's most widely used alcohol screening instrument and is available in approximately 40 languages. It is a self-administered questionnaire consisting of ten questions pertaining to an individual's alcohol use. Read additional details about the AUDIT tool in the following box.

AUDIT Screening Tool

- ▶ Review the full AUDIT tool: [Check Your Drinking: An Interactive self-test.](#)

The screening tool includes ten questions with answers ranging from 0 (Never) to 4 (4 or more times a week):

- How often do you have a drink containing alcohol?
- How many standard drinks containing alcohol do you have on a typical day when drinking?
- How often do you have six or more drinks on one occasion?
- During the past year, how often have you found that you were not able to stop drinking once you had started?
- During the past year, how often have you failed to do what was normally expected of you because of drinking?
- During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?
- During the past year, how often have you had a feeling of

8. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

guilt or remorse after drinking?

- During the past year, how often have you been unable to remember what happened the night before because you had been drinking?
- Have you or someone else been injured as a result of your drinking?
- Has a relative, friend, doctor, or other health worker been concerned about your drinking or suggested you cut down?

BRIEF INTERVENTIONS

Brief interventions is a term used to describe quick therapeutic techniques used to initiate change in individuals with unhealthy behaviors. For example, motivational interviewing (MI) is a client-centered therapeutic technique that can be used to address a person's ambivalence to change their use of substances. It uses a conversational approach to help the client discover their interest in changing their behavior. The nurse asks the client to express their desire for change and any ambivalence they might have and then begins to work with the client on making a plan to change their behavior and a commitment to the change process. Individuals who receive MI are more likely to adhere to a treatment plan and subsequently achieve better outcomes.⁹

9. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

REFERRAL

When an individual's substance use problem meets criteria for a substance use disorder or when brief interventions do not produce change, referral to specialized treatment should occur. This is called Screening, Brief Intervention, and Referral to Treatment (SBIRT). A referral for assessment and development of a clinical treatment plan is created with the client and tailored to meet their needs. Effective referral processes should incorporate strategies to motivate the client to accept the referral and assistance in navigating barriers for treatment.¹⁰

Compare the effectiveness of communication with a client being treated in the emergency department for injuries sustained when driving under the influence of alcohol in these YouTube videos:

▶ Video 1¹¹: [Anti-SBIRT \(Doctor A\)](#)

▶ Video 2 (Using SBIRT)¹²: [Using SBIRT Effectively \(Doctor B\)](#)

10. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

11. SBIRTInsitute. (2011, March 2). *Anti-SBIRT (Doctor A)*. [Video]. YouTube. All rights reserved. <https://youtu.be/ZGETDcFcAbI>

12. SBIRTInsitute. (2011, March 2). *Using SBIRT Effectively (Doctor B)*. [Video]. YouTube. All rights reserved. <https://youtu.be/uL8QyJF2wVw>

Treatment

Evidence-based treatment interventions include medications, behavioral therapies, and recovery services. Treatment can occur in a variety of settings, but treatment for severe substance use disorders has traditionally been provided in specialty substance use disorder treatment programs. The National Institute on Drug Abuse (NIDA) outlines the following evidence-based principles for effective treatment of adults and adolescents with substance use disorders^{13 14}:

- Substance use disorders are complex but treatable diseases that affect brain function and behavior. Psychoactive substances alter the brain's structure and function, resulting in changes that persist long after substance use has ceased. This may explain why individuals with substance use disorder are at risk for relapse even after long periods of abstinence and despite the potentially devastating consequences of their behaviors.
- No single treatment is appropriate for everyone. Treatment varies depending on the type of drug and the characteristics of the individuals. Matching treatment settings, interventions, and services to an individual's particular problems and needs is critical to their ultimate success in returning to productive functioning in the family, workplace, and society.
- Treatment must be readily available. Because individuals may be uncertain about entering treatment, taking advantage of available services the moment people are ready for treatment is critical. Potential clients can be lost if treatment is not immediately available or readily

13. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

14. National Institute on Drug Abuse. (2025). *Treatment*. <https://nida.nih.gov/research-topics/treatment>

accessible.

- Effective treatment attends to multiple needs of the individual, not just their substance abuse. To be effective, treatment must address the individual's substance abuse, as well as associated medical, psychological, social, vocational, and legal problems. It is also important that treatment is tailored to the individual's age, gender, ethnicity, and culture.
- Remaining in treatment for an adequate period of time is critical. The appropriate duration for an individual depends on the type and degree of the client's problems and needs. Research indicates that most addicted individuals need at least three months in treatment to significantly reduce or stop their substance use and that the best outcomes occur with longer durations of treatment. Recovery from substance use disorder is a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses can occur and should signal a need for treatment to be reinstated or adjusted. Because individuals often leave treatment prematurely, programs should include strategies to engage and keep clients in treatment.
- Behavioral therapies, including individual, family, or group counseling, are the most common types of treatment. Behavioral therapies vary in focus and may address a client's motivation to change, provide incentives for abstinence, build skills to resist drug use, replace substance-using activities with constructive and rewarding activities, improve problem-solving skills, and facilitate interpersonal relationships. Additionally, participation in group therapy and other peer support programs during and following treatment can help maintain abstinence.
- An individual's treatment plan must be continually evaluated and modified as needed to ensure it meets their changing needs. A client may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, clients may require medication, medical services, family therapy, parenting instruction, vocational rehabilitation, and/or social and legal services. For many clients, a recovery-oriented systems approach provides the best results, with the treatment intensity varying according to a person's changing needs.

- Many individuals with substance use disorders also have other mental health disorders. Treatment should address all conditions using appropriate medications.
- Treatment does not need to be voluntary to be effective. Sanctions or enticements from family, employment settings, and/or the criminal justice system can significantly increase treatment entry, retention rates, and the ultimate success of drug treatment interventions. Substance use during treatment must be monitored continuously because relapses during treatment do occur. Knowing their substance use is being monitored can be a powerful incentive for individuals to withstand urges to use substances. Monitoring also provides an early indication of a relapse, signaling an adjustment is needed in the individual's treatment plan to better meet their needs.
- Treatment programs should test clients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases, as well as provide targeted risk-reduction counseling. Many substance misuse-related behaviors put people at risk of infectious diseases. Targeted counseling reduces infectious disease. Counseling can also help those who are already infected to manage their illness. Moreover, engaging in substance abuse treatment can facilitate adherence to other medical treatments.

Medications

Medications are an important element of treatment for many clients, especially when combined with counseling and other behavioral therapies. For example, methadone, buprenorphine, and naltrexone are effective in helping individuals addicted to heroin or other opioids stabilize their lives and reduce their substance misuse. Acamprosate, disulfiram, and naltrexone are medications approved for treating alcohol dependence. For persons addicted to nicotine, a nicotine replacement product (available as patches, gum, lozenges, or nasal spray) or an oral medication (such as bupropion or varenicline) can be an effective component of treatment when part of a

comprehensive behavioral treatment program.¹⁵ See Table 14.7 for a list of medications approved by the FDA to treat alcohol and opioid use disorders.

Table 14.7 Pharmacotherapy to Treat Alcohol and Opioid Use Disorders¹⁶

15. National Institute on Drug Abuse. (2025). *Treatment*. <https://nida.nih.gov/research-topics/treatment>
16. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

Medication	Use	DEA Schedule	Application
Buprenorphine-naloxone	Opioid use disorder	CIII	Used for detoxification or maintenance of abstinence.
Methadone	Opioid use disorder	CII	Used for withdrawal and long-term maintenance of abstinence of opioid addiction. Dispersed only at opioid treatment centers certified by SAMHSA and approved by state authority.
Naltrexone	Opioid use disorder and alcohol use disorder	Not scheduled under the Controlled Substances Act	Block opioid receptors, reduce cravings, and diminish rewarding effects of opioids and alcohol. Extended-release injections are recommended to prevent relapse.
Acamprosate	Alcohol use disorder	Not scheduled under the Controlled Substances Act	Used for maintenance of alcohol abstinence.
Disulfiram	Alcohol use disorder	Not scheduled under the Controlled Substances Act	Causes severe physical reactions when alcohol is ingested, such as nausea, flushing, and heart palpitations. The knowledge that the reaction will occur acts as a deterrent to drinking alcohol.

Medically assisted detoxification is only the first stage of treatment and by itself does little to change long-term substance misuse. Although medically assisted detoxification can safely manage the acute physical symptoms of withdrawal, detoxification alone is rarely sufficient to help individuals achieve long-term abstinence of substances. Clients should be encouraged to continue long-term treatment and recovery services following detoxification.¹⁷

17. National Institute on Drug Abuse. (2025). *Treatment*. <https://nida.nih.gov/research-topics/treatment>

Behavioral Therapies

In addition to medications, effective treatment of SUD includes behavioral therapies to help clients recognize the impact of substance misuse on their interpersonal relationships and ability to function in a healthy, safe, and productive manner. Behavioral therapies also teach and motivate clients to change their behaviors as a way to control their substance use disorders.¹⁸ Evidence-based behavioral therapies include cognitive-behavioral therapy, dialectical behavior therapy, family therapy, contingency management, community reinforcement approach, motivational enhancement therapy, matrix model, and twelve-step facilitation. These therapies are further described in the following subsections.

COGNITIVE-BEHAVIORAL THERAPY

The theoretical foundation for cognitive-behavioral therapy (CBT) is that substance use disorders develop, in part, as a result of maladaptive behavior patterns and dysfunctional thoughts. As a result, CBT treatments involve techniques to modify such behaviors and improve coping skills by emphasizing the identification and modification of dysfunctional thinking. CBT is a short-term approach, usually involving 12 to 24 weekly individual sessions. These sessions typically explore the positive and negative consequences of substance use with self-monitoring as a mechanism to recognize cravings and other situations that may lead the individual to relapse. They also help the individual develop healthy coping strategies.

DIALECTICAL BEHAVIOR THERAPY

Dialectical behavior therapy (DBT) is an evidence-based therapy that teaches

18. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

a skill called mindfulness. Multiple research studies have noted that mindfulness is potentially useful in helping people diagnosed with SUD gain mastery over substance cravings.¹⁹

- ▶ Review information about cognitive-behavioral therapy and dialectical behavior therapy in the “[Treatments for Depression](#)” section of the “Depressive Disorders” chapter.

FAMILY THERAPY

Family behavior therapy (FBT) is a therapeutic approach used for both adolescents and adults that addresses not only substance use but also other issues the family may be experiencing, such as mental health disorders and family conflict. FBT includes up to 20 treatment sessions that focus on developing skills and setting behavioral goals. Basic necessities are reviewed and inventoried with the client, and the family pursues resolution strategies and addresses activities of daily living, including violence prevention and HIV/AIDS prevention.²⁰

19. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
20. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

CONTINGENCY MANAGEMENT

Behavior change involves learning new behaviors and changing old behaviors. Positive rewards or incentives for changing behavior can aid this process. Contingency management involves giving tangible rewards to individuals to support positive behavior change and has been found to effectively treat substance use disorders. In this therapy clients receive a voucher with monetary value that can be exchanged for food items, healthy recreational options (e.g., movies), or other sought-after goods or services when they exhibit desired behavior such as drug-free urine tests or participation in treatment activities. Clinical studies comparing voucher-based reinforcement to traditional treatment regimens have found that voucher-based reinforcement is associated with longer treatment engagement, longer periods of abstinence, and greater improvements in personal function. These positive findings, initially demonstrated with individuals with cocaine use disorders, have been reproduced in individuals with alcohol, opioid, and methamphetamine use disorders.²¹

COMMUNITY REINFORCEMENT APPROACH

Community reinforcement approach (CRA) plus vouchers is an intensive 24-week outpatient program that uses incentives and reinforcers to reward individuals who reduce their substance use. Individuals are required to attend one to two counseling sessions each week that emphasize improving relations, acquiring skills to minimize substance use, and reconstructing social activities and networks to support recovery. Individuals receiving this treatment are eligible to receive vouchers with monetary value if they provide drug-free urine tests several times per week. Research has demonstrated that

21. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

CRA plus vouchers promotes treatment engagement and facilitates abstinence.²²

MOTIVATIONAL ENHANCEMENT THERAPY

Motivational enhancement therapy (MET) uses motivational interviewing techniques to help individuals resolve any uncertainties they have about stopping their substance use. MET works by promoting empathy, developing client awareness of the discrepancy between their goals and their unhealthy behavior, avoiding argument and confrontation, addressing resistance, and supporting self-efficacy to encourage motivation and change. The therapist supports the client in executing the behaviors necessary for change and monitors progress toward client-expressed goals.²³

MATRIX MODEL

The matrix model is a structured, multi-component behavioral treatment that consists of evidence-based practices, including relapse prevention, family therapy, group therapy, drug education, and self-help, delivered in a sequential and clinically coordinated manner. The model consists of 16 weeks of group sessions held three times per week, which combine CBT, family education, social support, individual counseling, and urine drug testing.²⁴

22. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

23. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

24. Substance Abuse and Mental Health Services Administration, & Office of the

TWELVE-STEP FACILITATION

Twelve-step facilitation (TSF), an individual therapy typically delivered in 12 weekly sessions, is designed to prepare individuals to understand, accept, and become engaged in Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or similar 12-step programs.²⁵ Twelve-step programs are further discussed under the “Recovery Support Services” section below.

TSF focuses on three key ideas:

- Acceptance: Realizing that their substance use is part of a disorder, that life has become unmanageable because of alcohol or drugs, that willpower alone will not overcome the problem, and that abstinence is the best alternative
- Surrender: Giving oneself to a higher power, accepting the fellowship and support structure of other recovering individuals, and following the recovery activities laid out by a 12-step program
- Active involvement in a 12-step program

Recovery Support Services

In addition to medications and behavioral therapies, effective treatment of SUD includes recovery support services (RSS). Recovery support services provided by substance use disorder treatment programs and community organizations provide support to individuals receiving treatment for SUD, as well as ongoing support after treatment. These supportive services are

Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

25. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

typically delivered by trained case managers, recovery coaches, and/or peers. Specific RSS include assistance in navigating systems of care, removing barriers to recovery, staying engaged in the recovery process, and providing a social context for individuals to engage in community living without substance use. RSS can be effective in promoting healthy lifestyle techniques to increase resilience skills, reduce the risk of relapse, and help achieve and maintain recovery. Individuals who participate in RSS typically have better long-term recovery outcomes.²⁶

Recovery goes beyond abstinence and the remission of substance use disorder to include a positive change in the whole person. There are many paths to recovery. People choose their individual pathway based on their cultural values, socioeconomic status, psychological and behavioral needs, and the nature of their substance use disorder.²⁷

A study of over 9,000 individuals with previous substance use disorders asked how they defined recovery. These three themes emerged²⁸:

- **Abstinence:** 86 percent viewed abstinence as part of their recovery, but

26. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
27. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
28. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

the remainder did not think abstinence was important for their recovery. However, abstinence was considered “essential” by those affiliated with 12-step mutual aid groups.

- **Personal growth:** “Being honest with myself” was endorsed as part of recovery by 98 percent of participants. Other almost universally endorsed elements included “handling negative feelings without using alcohol or drugs” and “being able to enjoy life without alcohol or drugs.” Almost all study participants viewed their recovery as a process of growth and development, and about two thirds saw it as having a spiritual dimension.
- **Service to others:** Engaging in service to others was another prominent component of how study participants defined recovery. This is perhaps because during periods of heavy substance misuse, individuals may damage interpersonal relationships, which they later regret and attempt to resolve during recovery. Service to others has evidence of helping individuals maintain their own recovery.²⁹

Recovery-Oriented Systems of Care (ROSC) embrace the idea that severe substance use disorders are most effectively addressed through a chronic care management model that includes long-term, outpatient care, recovery housing, and recovery coaching and management checkups. ROSC are designed to be easy to navigate for people seeking help, transparent in their operations, and responsive to the cultural diversity of the communities they serve. ROSC often use long-term recovery management protocols, such as recovery management checkups and telephone case monitoring.³⁰

29. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

30. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's*

Even when remission is achieved after one or two years, it can take four to five more years before an individual's risk of relapse drops below 15 percent (the level of risk that people in the general population have of developing a substance use disorder in their lifetime). As a result, similar to other chronic illnesses, a person with a serious substance use disorder often requires ongoing monitoring and management to maintain remission and to provide early reintervention should relapse occur. Recovery support services (RSS) refer to the collection of community services that can provide emotional and practical support for continuing remission, as well as daily structure and rewarding alternatives to substance use. Recovery supports include services such as mutual aid groups, recovery coaches, recovery housing, community care, and education-based recovery support.

MUTUAL AID GROUPS

Mutual aid groups, such as 12-step groups, are well-known recovery supports, and they share a number of features. Members share their substance use problem and value learning from each other's experiences as they focus on personal-change goals. The groups are voluntary associations that charge no fees and are member-led.

Alcoholics Anonymous

Alcoholics Anonymous (AA) has been in existence since 1935. Its philosophy, approach, and format have been adapted by groups focusing on recovery from other substances, such as Narcotic Anonymous, Cocaine Anonymous, Marijuana Anonymous, and Crystal Meth Anonymous. AA and derivative programs share two major components: social fellowship and a 12-step program of action that was formulated based on members' experiences of recovery from severe alcohol use disorders. These 12 steps are ordered in a

report on alcohol, drugs, and health. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

logical progression, beginning with accepting that one cannot control one's substance use, followed by abstaining from substances permanently, and transforming one's spiritual outlook, character, and relationships with other people.³¹

Research studying 12-step mutual aid groups, specifically those focused on alcohol, has shown that participation in the groups promotes an individual's recovery by strengthening recovery-supportive social networks; increasing members' abilities to cope with risky social contexts and negative emotions; augmenting motivation to recover; reducing depression, craving, and impulsivity; and enhancing psychological and spiritual well-being.³²

► Find a local Alcoholics Anonymous group near you: [Find A.A. Near You](#)

Al-Anon and Alateen

Friends and family members often suffer when a loved one has a substance use disorder. This can include worrying about their loved one experiencing accidents, injuries, legal consequences, diseases, or death or experiencing verbal or physical abuse. Mutual aid groups provide emotional support to

31. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
32. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

concerned significant others to help them systematically and strategically cope with the problems related to the substance misuse of their loved one.³³

Al-Anon is a mutual aid group for family members dealing with substance misuse in a loved one. Like AA, Al-Anon is based on a 12-step philosophy and provides support whether or not members' loved ones seek help or achieve remission or recovery. More than 80 percent of Al-Anon members are women. The principal goal of Al-Anon is to foster emotional stability and "loving detachment" from the loved one rather than coaching members to "get their loved one into treatment or recovery." Al-Anon includes Alateen that focuses on the specific needs of adolescents affected by a parent's or other family member's substance use. Research studies regarding the effectiveness of Al-Anon show that participating family members experience reduced depression, anger, and relationship unhappiness at rates comparable to those of individuals receiving psychological therapies.³⁴

► Find a local Al-Anon group near you: [Al-Anon Meetings](#)

RECOVERY COACHES

Voluntary and paid recovery coaches help individuals discharging from

33. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
34. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

treatment to connect to community services while addressing any barriers or problems that may hinder the recovery process. A recovery coach's responsibilities may include providing strategies to maintain abstinence, connecting people to recovery housing and social services, and helping people develop personal skills that maintain recovery.³⁵

RECOVERY HOUSING

Recovery-supportive houses provide both a substance-free environment and mutual support from fellow recovering residents. Many residents stay in recovery housing during or after outpatient treatment, with self-determined residency lasting for several months to years. Residents often informally share resources and give advice based on their experience in accessing health care, finding employment, managing legal problems, and interacting with the social service system.³⁶

COMMUNITY CARE

Recovery community centers may host mutual aid group meetings; offer recovery coaching, education, and social events; and provide access to other resources such as housing, education, and employment. Some recovery community centers encourage community members to engage in advocacy

35. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
36. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

to combat negative public attitudes, educate the community, and improve supports for recovery in the community.³⁷

EDUCATION-BASED RECOVERY SUPPORT

Education-based recovery support services are designed to help individuals in early substance use disorder recovery achieve their educational goals while also focusing on the areas of their social, emotional, spiritual, and physical well-being needed to help sustain recovery. High school and college environments can be difficult for students in recovery because of high levels of substance misuse among other students, peer pressure to engage in substance use, and widespread availability of alcohol and drugs. High school and collegiate recovery support programs provide recovery-supportive environments and peer engagement with other students in recovery.³⁸

Planning Individualized Treatment

After an individual is assessed and diagnosed with substance use disorder (SUD) by a trained professional based on criteria in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR)*, a collaborative, personalized treatment plan is designed with the client to meet their specific needs. The treatment plan and goals should be person-centered and include strength-based approaches that draw upon an individual's strengths and resources to keep them engaged in care. Individualized treatment plans

37. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
38. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

should consider age, gender identity, race and ethnicity, language, health literacy, religion/spirituality, sexual orientation, culture, trauma history, and co-occurring physical and mental health problems. This increases the likelihood of successful treatment engagement and retention. Throughout treatment, individuals should be periodically reassessed to determine response to treatment and to make any needed adjustments to the treatment plan.³⁹

Nurses can improve engagement and retention in treatment programs by building a strong therapeutic alliance with the client, effectively using evidence-based motivational strategies, acknowledging the client's individualized barriers, and creating a positive environment. Referring individuals to recovery support services, such as child care, housing, and transportation, can also improve retention in treatment.⁴⁰

Treatment Settings and Continuum of Care

The treatment of severe substance use disorder is typically delivered in freestanding programs in various settings (e.g., hospital, residential, or outpatient settings) that vary in the frequency of care delivery (e.g., daily sessions to monthly visits), range of treatment components offered, and planned duration of care. As clients progress in treatment and begin to meet the goals of their individualized treatment plan, they transfer from clinical

39. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

40. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

management in residential or intensive outpatient programs to less clinically intensive outpatient programs that promote client self-management.⁴¹

A typical progression for someone who has a severe substance use disorder might start with 3 to 7 days in a medically managed withdrawal program, followed by a 1- to 3-month period of intensive rehabilitative care in a residential treatment program, followed by intensive outpatient program (2 to 5 days per week for a few months) and later in a traditional outpatient program that meets 1 to 2 times per month. For many clients whose current living situations are not conducive to recovery, outpatient services should be provided in conjunction with recovery-supportive housing. In general, clients with serious substance use disorders are recommended to stay engaged for at least one year in the treatment process, which may involve participating in three to four different programs or services at reduced levels of intensity, all of which are ideally designed to help the client prepare for continued self-management after treatment ends.⁴²

The levels of the treatment continuum include the following:

- **Medically monitored and managed inpatient care:** An intensive service delivered in an acute, inpatient hospital setting. These programs are typically necessary for individuals who require withdrawal management, primary medical and nursing care, and for those with co-occurring mental and physical health conditions. Treatment is available 24 hours a

41. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

42. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

day and usually provided by an interdisciplinary team of health care professionals who can address serious mental and physical health needs.

- **Residential services:** Organized services, also in a 24-hour setting but outside of a hospital. These programs typically provide support, structure, and an array of evidence-based clinical services. Such programs are appropriate for physically and emotionally stabilized individuals who may not have a living situation that supports recovery, may have a history of relapse, or have co-occurring physical and/or mental health illnesses.
- **Partial hospitalization and intensive outpatient services:** Services range from counseling and education to clinically intensive programming. Partial hospitalization programs are used as a step-down treatment option after completing residential treatment and are usually available 6 to 8 hours a day during the work week. These services are considered to be approximately as intensive but less restrictive than residential programs and are appropriate for clients living in an environment that supports recovery but who need structure to avoid relapse.
- **Outpatient services:** Group and individual behavioral interventions and medications when appropriate. These components of care can be offered during the day, before or after work or school, or in the evenings and weekends. Typically, outpatient programs are appropriate as the initial level of care for individuals with a mild to moderate substance use disorder or as continuing care after completing more intensive treatment. Outpatient programs are also suitable for individuals with concurrent mental health conditions.

Helping Individuals in Need of Treatment

Despite the fact that substance use disorders are widespread, only a small percentage of people receive treatment because of the barriers previously discussed. Results from the 2020 National Survey of Drug Use and Health (NSDUH) indicate that among people aged 12 or older in 2020, 14.9 percent (or 41.1 million people) needed substance use treatment in the past year (defined if they had a SUD diagnosed in the past year or if they received substance use

treatment at a specialty facility in the past year). There are many common reasons people do not seek treatment⁴³:

- Not ready to stop using (40.7 percent)
- Do not have health care coverage/could not afford (30.6 percent)
- Perceived negative effect on their job (16.4 percent) or cause neighbors/community to have a negative opinion (8.3 percent)
- Do not know where to go for treatment (12.6 percent) or no program has the type of treatment desired (11.0 percent)
- Do not have transportation, the programs are too far away, or hours are inconvenient (11.8 percent)

Nurses can use motivational interviewing strategies to explore clients' reasons for not seeking treatment and address their perceived barriers to treatment.

Strategies to Reduce Harm

Strategies to reduce the harm associated with substance use have been developed to engage people in treatment, as well as address the needs of individuals who are not yet ready to participate in treatment. Harm reduction programs provide public health services to prevent and reduce substance use-related risks among those actively using substances. Strategies include outreach and education programs, needle/syringe exchange programs, overdose prevention education, and improving public access to naloxone to reverse potentially lethal opioid overdose. These strategies are designed to reduce negative consequences for people with substance use disorders and those around them, such as overdose and the transmission of HIV and other

43. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

infectious diseases. They also encourage individuals to seek treatment to reduce, manage, and stop their substance use.⁴⁴

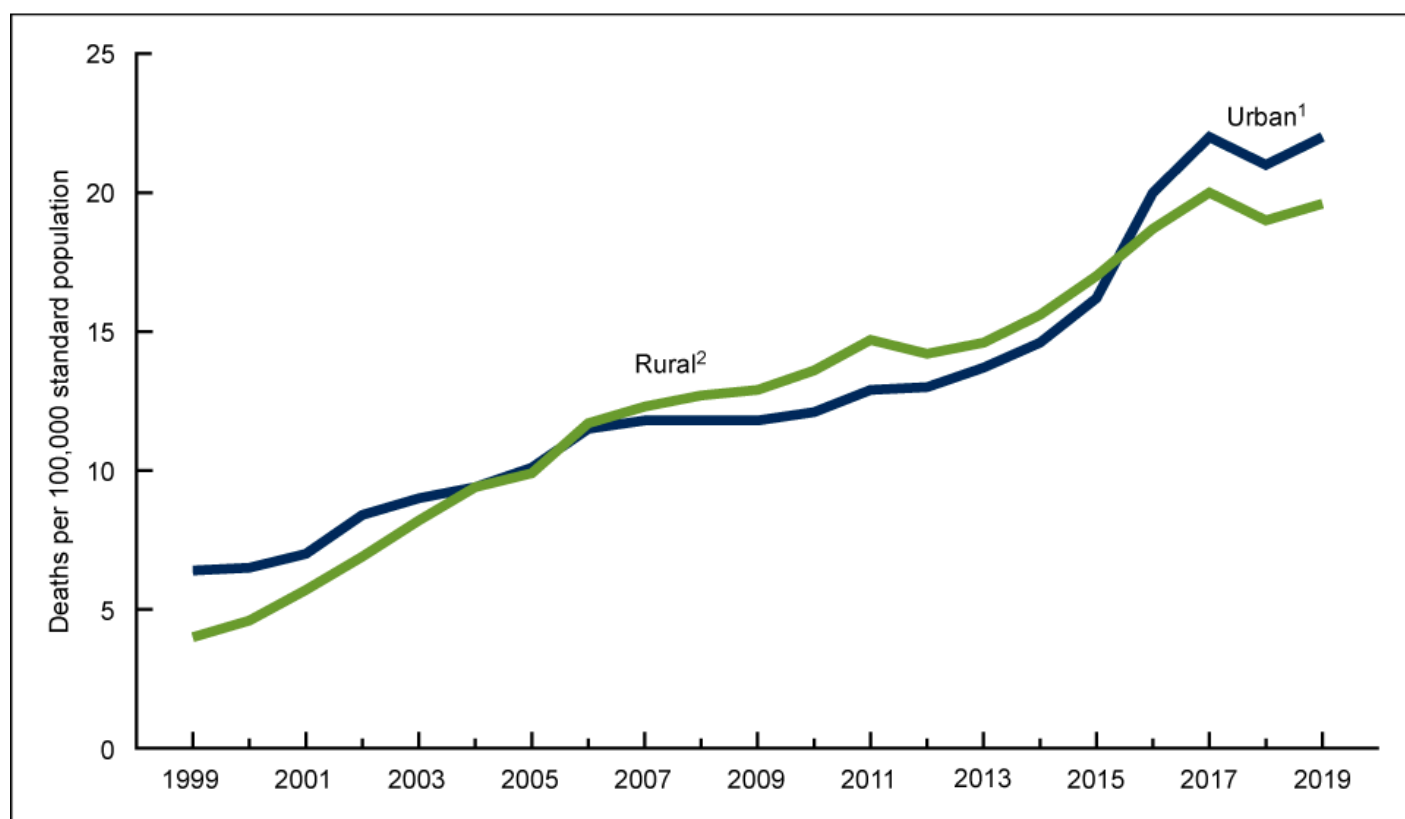
44. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

14.8 Prevention of Substance Use Disorders

The misuse of alcohol and drugs and substance use disorders has a significant impact on public health in the United States. The Centers for Disease Control and Prevention (CDC) reports over 80,000 drug overdose deaths occurred in the United States in 2024, and overdose deaths in urban and rural populations have shown a significant upward trend over the past 20 years.¹ See Figure 14.11² for a graphic of overdose rates in urban and rural areas.

1. National Center for Health Statistics. (2025). *Provisional drug overdose death counts*. <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>
2. “db403-fig1.png” from by Hedegaard, H., & Spencer, M. R. is in the [Public Domain](#). Access the full report at <https://www.cdc.gov/nchs/products/databriefs/db403.htm#fig1>.

Figure 1. Age-adjusted rates of drug overdose deaths, by urban and rural residence: United States, 1999–2019



¹Significant increasing trend from 1999 to 2017, with different rates of change over time; stable trend from 2017 through 2019, $p < 0.05$.

²Significant increasing trend from 1999 through 2019, with different rates of change over time, $p < 0.05$.

NOTES: Drug overdose deaths were identified using *International Classification of Diseases, 10th Revision* underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. Age-adjusted death rates were calculated using the direct method and the 2000 U.S. standard population. Decedent's county of residence was classified as urban or rural based on the 2013 NCHS Urban–Rural Classification Scheme for Counties. Access data table for Figure 1 at: <https://www.cdc.gov/nchs/data/databriefs/db403-tables-508.pdf#1>.

SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

Figure 14.11 Drug Overdose Rates in Urban and Rural Areas

Substance misuse is associated with a wide range of health and social problems, including heart disease, stroke, high blood pressure, various cancers (e.g., liver, lung, and colon cancer), mental health disorders, neonatal abstinence syndrome, driving under the influence (DUI) injuries and fatalities, incarcerations, sexual assaults and rapes, unintended pregnancies, sexually transmitted infections, and bloodborne pathogens like hepatitis and human immunodeficiency virus (HIV).³ Given the impact of substance misuse on

3. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

public health, it is critical to implement preventative interventions to stop substance misuse from starting, as well as to identify and intervene early with individuals who have already begun to misuse substances.

Promoting Protective Factors

Experiencing a family member's substance use disorder is considered an adverse childhood event (ACE) that can impact a child's risk for developing behavioral problems, substance misuse, and chronic illness. Targeted prevention programs implemented at the family, school, and individual levels can complement broader population-level policies by promoting protective factors for children and adolescents.

► Read more about ACEs in the “[Adverse Childhood Experiences](#)” section of the “Trauma, Abuse, and Violence” chapter.

Protective factors help prevent substance use disorders from developing despite the presence of risk factors. Protective factors exist at the individual, family, school, and community levels.

Examples of interventions to promote protective factors at the individual level include the following⁴:

- **Social, emotional, and behavioral competence:** Promoting interpersonal skills that help youth integrate feelings, thoughts, and actions to achieve specific social and interpersonal goals.
- **Self-efficacy:** Enhancing an individual's belief that they can modify,

4. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

control, or abstain from substance use.

- **Spirituality:** Supporting beliefs in a higher being or involvement in spiritual practices or religious activities.
- **Resiliency:** Encouraging an individual's capacity for adapting to change and coping with stressful events in healthy and flexible ways.

Interventions to promote protective factors at the family, school, and community levels are as follows⁵:

- **Opportunities for positive social involvement:** Creating developmentally appropriate opportunities to be meaningfully involved with the family, school, or community.
- **Recognition for positive behavior:** Providing community and family recognition of individuals' efforts and accomplishments to encourage positive future behaviors.
- **Bonding:** Promoting attachment, commitment, and positive communication with family members, schools, and communities.
- **Marriage or committed relationships:** Encouraging committed relationships with people who do not misuse alcohol or drugs.
- **Healthy beliefs and standards for behavior:** Establishing family, school, and community norms that communicate clear and consistent expectations about not misusing alcohol or drugs.

Prevention Interventions

The Institute of Medicine describes three categories of prevention interventions: universal, selective, and indicated. Universal interventions are aimed at all members of a given population, selective interventions are aimed at a subgroup determined to be at high-risk for substance use, and indicated

5. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

interventions are targeted for individuals who are already misusing substances but have not developed a substance use disorder. Examples of evidence-based prevention interventions for each category are provided in the following subsections.

Universal Interventions

Universal interventions include policies that affect the entire population, such as the setting the minimum legal drinking age or reducing the availability of substances in a community. For example, laws targeting alcohol-impaired driving, such as license revocation for impaired driving and 0.08 legal blood alcohol (BAC) limits have helped cut alcohol-related traffic deaths per 100,000 in half since the early 1980s.⁶

Several family-focused, universal prevention interventions show substantial preventive effects on substance use. Two examples are the Strengthening Families Program and the I Hear What You're Saying program⁷:

- **Strengthening Families Program (SFP):** A widely used seven-session, family-focused program that enhances parenting skills, such as nurturing, setting limits, and communicating, as well as promoting adolescents' skills in refusing substances. Across multiple studies conducted in rural United States communities, SFP showed reductions in tobacco, alcohol, and drug use up to nine years after the intervention (i.e., to age 21)

6. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

7. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

compared with youth who were not assigned to the SFP. SFP also shows reductions in prescription drug misuse up to 13 years after the intervention (i.e., to age 25). Strong African American Families, a cultural adaptation of SFP, shows reductions in early initiation and rate of alcohol use for Black or African American rural youth.

- **I Hear What You're Saying:** An Internet-based program that involves nine 45-minute sessions to improve communication, establish family rules, and manage conflict. Specifically focused on mothers and daughters, follow-up results showed lower rates of substance use in an ethnically diverse sample.⁸

Selective Interventions

Selective interventions are delivered to particular communities, families, or children who, due to exposure to risk factors, are at increased risk of substance misuse problems. Target audiences may include families living in poverty, the children of substance-misusing parents, or children who have difficulties with social skills. Selective interventions deliver specialized prevention services to individuals with the goal of reducing identified risk factors, increasing protective factors, or both. Examples of selective intervention programs are the Nurse-Family Partnership, Familias Unidas, and Brief Alcohol Screening and Intervention for College Students⁹:

8. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
9. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

- **Nurse-Family Partnership:** A program focused on children younger than age 5 has shown significant reductions in the use of alcohol in the teen years compared with those who did not receive the intervention. Trained nurses provide an intensive home visitation intervention for at-risk, first-time mothers during pregnancy. This intervention provides ongoing education and support to improve pregnancy outcomes, infant health, and development of parenting skills.¹⁰
- **Familias Unidas:** A family-based intervention for Hispanic or Latino youth that includes both multi-parent groups (eight weekly 2-hour sessions) and four to ten 1-hour individual family visits. It has been shown to lower substance use or delay the start of substance use among adolescents.¹¹
- **Brief Alcohol Screening and Intervention for College Students (BASICS):** A brief motivational intervention designed to help students reduce alcohol misuse and negative consequences of their drinking. It consists of two 1-hour interviews with a brief online assessment after the first session. The first interview gathers information about alcohol consumption patterns and personal beliefs about alcohol while providing instructions for self-monitoring drinking between sessions. The second interview uses data from the online assessment to develop personalized, normative feedback that reviews negative consequences and risk factors, clarifies perceived risks and benefits of drinking, and provides options for reducing alcohol use and its consequences. Follow-up studies of students who used BASICS have shown reductions in the quantity of drinking in

10. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

11. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

the general college population, as well as fraternity members.

Indicated Prevention Interventions

Indicated prevention interventions are directed to those who are already involved in substance misuse but who have not yet developed a substance use disorder. An example of an indicated prevention intervention is Coping Power, a 16-month program for children in Grades 5 and 6. The program uses skills-based training to increase social competence, self-regulation, and positive parental involvement. Results include reduced substance use, delinquency, and aggressive behaviors.¹²

12. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

14.9 Applying the Nursing Process to Substance Use Disorders

Assessment (Recognizing Cues)

Mental Status Examination

See Table 14.9a for common findings when assessing a client with a substance use disorder. (See expected findings for these components of a mental status examination in the “[Assessment](#)” section in Chapter 4.) Critical findings that require immediate notification of the provider are bolded with an asterisk. This table helps identify clinical features that may present during intoxication, withdrawal, or long-term substance use and supports a comprehensive nursing assessment.

Table 14.9a Common Findings During Mental Status Examinations for Clients With Substance Use Disorders¹

1. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

Mental Status Examination Component	Common Findings in Substance Use Disorders (*Indicates immediately notify provider)
Signs of Distress	May present with anxiety, agitation, physical discomfort, or withdrawal symptoms (e.g., tremors, sweating, nausea). May appear drowsy, euphoric, or dysregulated depending on the substance used and timing.
Level of Consciousness and Orientation	Varies with substance type and use pattern. May be fully alert or display fluctuating levels of consciousness, confusion, or disorientation—especially during withdrawal or overdose of alcohol, opioids, and benzodiazepines.
Appearance and General Behavior	May appear disheveled or neglected, especially with chronic use of a substance. Signs of intoxication or withdrawal may include dilated or constricted pupils, slurred speech, or slowed/increased movements. Behavior may be guarded, restless, or impulsive. Track marks may be present for those using IV substances.
Speech	Speech may be slurred, rapid, pressured, or incoherent, depending on substance being used.
Motor Activity	May display tremors, psychomotor agitation (e.g., pacing, jitteriness), retardation (e.g., sedation), or repetitive movements. Falls, unsteadiness, or hyperactivity may also occur.
Mood and Affect	Mood may fluctuate based on substance used and timing. Mood may be euphoric, irritable, anxious, depressed, or flat. Clients may appear emotionally labile or detached. Intoxication may mask the client's true emotional state and withdrawal may increase distress.

Thought and Perception	Thought content may include denial, guilt, paranoia, or preoccupation with obtaining substances. In severe intoxication or withdrawal, hallucinations, delusions, or psychosis may occur (e.g., alcohol-induced hallucinosis).
Attitude and Insight	Insight is often impaired—clients may minimize or deny the extent of use or its consequences. Attitude may range from cooperative to guarded, defensive, or evasive depending on trust and withdrawal status.
Cognitive Abilities and Level of Judgment	Impaired attention, memory deficits, or poor concentration are common. Long-term use may cause cognitive slowing (e.g., in alcohol or benzodiazepine use). Executive function and judgment may be compromised.

Psychosocial Assessment

A comprehensive psychosocial assessment includes the following components:

- Reason for seeking health care (i.e., “chief complaint”)
- Thoughts of suicide or self injury
- Cultural assessment
- Spiritual assessment
- Family dynamics
- Current and past medical history
- Current medications
- History of previously diagnosed mental health disorders
- Previous hospitalizations
- Educational background
- Occupational background
- History of exposure to psychological trauma, violence, and domestic abuse

- Substance use (tobacco, alcohol, recreational drugs, misused prescription drugs)
- Family history of mental illness
- Coping mechanisms
- Functional ability/Activities of daily living

After identifying the reason the client is seeking health care, additional focused questions are used to obtain detailed information. The mnemonic PQRSTU can be used to ask questions in an organized fashion. See Table 14.9b for a sample PQRST assessment for a client experiencing an alcohol use disorder.

Table 14.9b Sample PQRSTU Questions for Assessing Alcohol Use Disorder

PQRSTU	Sample Questions
Provocation/ Palliation	“What usually leads you to drink?” “What helps you cut back or stop, even temporarily?”
Quality	“How would you describe your drinking experience—what does it do for you?”
Region	“Do you notice any physical effects when you drink or stop drinking?”
Severity	“How much has drinking affected your health, work, or relationships?”
Timing/ Treatment	“When did you start drinking regularly?” “How has your drinking changed over time?”
Understanding	“Why do you think this problem developed?” “What do you believe needs to happen to stop this problem?”

SUICIDE AND SELF INJURY SCREENING

Clients being evaluated or treated for substance use disorders may have suicidal ideation. It is important for the nurse to introduce suicide screening in a way that helps the client understand its purpose and normalize questions that might otherwise seem intrusive. The Patient Safety Screener (PSS-3) is an

example of a brief screening tool to detect suicide risk in all client presenting to acute care settings.²

Non-suicidal self-injury (NSSI) refers to intentional self-inflicted destruction of body tissue without suicidal intention and for purposes not socially sanctioned. Common forms of NSSI include behaviors such as cutting, burning, scratching, and self-hitting. It is considered a maladaptive coping strategy without the desire to die. NSSI is a common finding among adolescents and young adults in psychiatric inpatient settings.³

Review information about suicide screening, the Patient Safety Screener, and screening for non-suicidal self-injury (NSSI) in the “[Assessment](#)” section of the Applying the Nursing Process to Mental Health Care” chapter.

CULTURAL ASSESSMENT

Cultural Formulation Interview (CFI) questions help nurses understand a client’s cultural background and how it influences their experience of substance use disorder.⁴ Sample CFI questions focused specifically on understanding alcohol use disorder within a cultural context include the following:

2. Suicide Prevention Resource Center. (n.d.). *The patient safety screener: A brief tool to detect suicide risk*. <https://sprc.org/micro-learning/patientsafetyscreener>
3. Cipriano, A., Cella, S., & Cotrufo, P. (2017). Nonsuicidal self-injury: A systematic review. *Frontiers in Psychology*, 8. <https://www.frontiersin.org/articles/10.3389/fpsyg.2017.01946/full>
4. DeSilva, R., Aggarwall, N. K., & Lewis-Fernandez, R. (2015). The DSM-5 cultural formulation interview and the evolution of cultural assessment in psychiatry. *Psychiatric Times*, 32(6). <https://www.psychiatrictimes.com/view/dsm-5-cultural-formulation-interview-and-evolution-cultural-assessment-psychiatry>

- Cultural Definition of the Problem
 - “How would you describe your drinking problem to someone close to you?”
 - “What terms or labels are used in by your friends or family to talk about heavy drinking?”
 - “Do people around you see your drinking as a problem?”
- Cultural Perceptions of Cause, Context, and Support
 - “Why do you think drinking became an issue for you?”
 - “How is alcohol used in your family or community? Is it used in celebrations, rituals, or as a coping tool?”
 - “Do you feel pressure—positive or negative—from your family or friends related to your drinking?”
- Cultural Factors Affecting Coping and Help-Seeking
 - “Have you tried anything on your own to manage your drinking? What helped and what didn’t?”
 - “Are there any traditional practices, herbs, or dietary supplements you have tried to use to manage it?”
 - “Do people in your community seek help for alcohol-related issues? If so, from whom (e.g., religious leaders, clinics, family)?”
 - “What kinds of treatment or help do you think would be most useful or acceptable to you?”
- Cultural Features of the Nurse–Client Relationship
 - “Are there any concerns you have about talking to a mental health professional?”
 - “Would you feel more comfortable speaking with someone of a similar gender, cultural, or religious background?”
 - “What would help you feel more supported or understood during treatment?”
 - “Have you had past experiences with healthcare or addiction treatment that were helpful or unhelpful?”

Findings from the cultural formulation interview are used to individualize a client’s plan of care to their preferences, values, beliefs, and goals.

SPIRITUAL ASSESSMENT

The FICA Spiritual History Tool is a widely used assessment model for evaluating a client's spiritual beliefs and how they may influence health, illness, and coping. It's especially helpful in understanding how clients with substance use disorders draw on spirituality or religion for support—or how spiritual distress may be contributing to feelings of anxiety. Addressing a client's spirituality and advocating spiritual care have been shown to improve clients' health and quality of life.^{5,6}

The FICA Spiritual History Tool© is a common tool used to gather information about a client's spiritual history and preferences. FICA© is a mnemonic for the domains of Faith, Importance, Community, and Address in Care.⁷ Table 14.9c summarizes a sample FICA Spiritual Assessment for a client with a substance use disorder.

Table 14.9c Sample FICA Spiritual Assessment Questions for Clients with a Substance Use Disorder

5. Pilger, C., Molzahn, A. E., de Oliveira, M. P., & Kusumota, L. (2016). The relationship of the spiritual and religious dimensions with quality of life and health of patients with chronic kidney disease: An integrative literature review. *Nephrology Nursing Journal: Journal of the American Nephrology Nurses' Association*, 43(5), 411–426. <https://pubmed.ncbi.nlm.nih.gov/30550069/>
6. Puchalski, C., Jafari, N., Buller, H., Haythorn, T., Jacobs, C., & Ferrell, B. (2020). Interprofessional spiritual care education curriculum: A milestone toward the provision of spiritual care. *Journal of Palliative Medicine*, 23(6), 777–784. <https://doi.org/10.1089/jpm.2019.0375>
7. GW School of Medicine & Health Sciences. (n.d.). *Clinical FICA tool*. <https://smhs.gwu.edu/spirituality-health/program/transforming-practice-health-settings/clinical-fica-tool>

Domain	Sample Assessment Question	Sample Client Response
Faith	“Do you have spiritual beliefs or religious faith that help you cope with challenges or give your life meaning?”	“Yes, I believe in God and used to go to church, especially when I was trying to get sober. But I’ve drifted away because I feel ashamed about using.”
Importance	“What importance does your faith or belief have in your life? Has it influenced how you cope with stress or your anxiety?”	“They’re still important to me, but I don’t feel like I’m living life the way I should be. God will probably punish me for all I’ve done.”
Community	“Are you part of a spiritual or religious community? Does participation in this community provide support when you’re feeling anxious or stressed?”	“I haven’t gone back to church since I relapsed. I don’t want to be judged.”
Address in Care	“How would you like me (or the health care team) to address spiritual issues during your care? Would you like to speak with a chaplain?”	“Yes I would be interested in speaking to someone who will listen and not judge me.”

Nurses may recognize cues of spiritual distress or beliefs in divine punishment that may exacerbate feelings of anxiety. Nurses can offer to connect the client with a chaplain or spiritual care services. Spiritual goals may be included in the nursing care plan if the client finds them valuable.

History

The following client history should be obtained from a client diagnosed with a substance use disorder⁸:

- **History of substance use:** Include names of the substances used, the time of last use, the duration of use, the quantity and frequency of use, and the method of use (e.g., oral, intravenous, inhaled, intranasal). A

8. Pace, C. (2022). Alcohol withdrawal: Epidemiology, clinical manifestations, course, assessment, and diagnosis. *UpToDate*. www.uptodate.com

detailed substance use history helps determine the expected time frame for emergence of withdrawal symptoms and the potential for severe withdrawal syndromes. Family history of substance use.

- **Detailed history of previous withdrawal treatments & treatment history:** For clients who have previously undergone withdrawal management, a history of these treatments should be obtained. The history of any previous treatment programs should be obtained. History should include previous treatments (such as inpatient or outpatient programs, 12-step programs such as Alcoholics Anonymous, or medications such as naltrexone or acamprosate), as well as what treatments have been helpful or not helpful.
- **Mental health history:** Concurrent mental health illness can impact the client's withdrawal symptoms. Clients should receive integrated post-withdrawal treatments for multiple diagnoses of mental health and substance use disorders.
- **Social history:** Identification of social supports (such as a supportive family member who can encourage abstinence and potentially dispense withdrawal medication), as well as barriers (such as poor transportation), can also help determine the most appropriate post-withdrawal treatment plan (e.g., residential, outpatient, and recovery programs).
- **Medical history and recent physical symptoms:** Medical problems can contribute to the client's symptoms and/or worsen withdrawal symptoms.

The client should receive a comprehensive physical examination to evaluate signs related to current withdrawal symptoms, as well as symptoms of concurrent medical and mental health diagnoses. If the client has been diagnosed with alcohol use disorder, signs of complications such as liver or pancreatic disease should be assessed.⁹

9. Pace, C. (2022). Alcohol withdrawal: Epidemiology, clinical manifestations, course, assessment, and diagnosis. *UpToDate*. www.uptodate.com

Screening Scales

Screening scales may be administered such as CIWA-aR (for alcohol withdrawal symptoms) and COWS (for opioid withdrawal symptoms). Read more information about these scales in the “[Withdrawal Management/Detoxification](#)” section of this chapter.

Diagnostic and Lab Work

Laboratory testing for clients admitted for withdrawal treatment may include these items¹⁰:

- Complete blood count
 - Serum electrolytes, including potassium, magnesium, and phosphate
 - Glucose
 - Creatinine
 - Liver function tests
 - Amylase and lipase
 - Blood alcohol level
 - Urine drug testing for benzodiazepines, cocaine, and opioids. (The opioid test may include testing for heroin, codeine, morphine, buprenorphine, oxycodone, methadone, and fentanyl.)
-
- Urine human chorionic gonadotropin (HCG) test for premenopausal women to check for pregnancy
 - Electrocardiogram (ECG) for clients over 50 years of age or if there is a history of cardiac problems

10. Pace, C. (2022). Alcohol withdrawal: Epidemiology, clinical manifestations, course, assessment, and diagnosis. *UpToDate*. www.uptodate.com

Life Span Considerations

Children and Adults

In 2020, nearly 10 million U.S. adolescents met the diagnostic criteria for a substance use disorder, and the majority were untreated. In the United States, more than 90% of adults with SUDs began their substance use in adolescence.¹¹ Adolescents with SUDs are at greater lifetime risk for sexually transmitted diseases, poor family planning, justice system involvement, school-related challenges, neurocognitive impairments, and increased risk of mental health disorders. Adolescent substance use is associated with the leading causes of death of unintentional injury, suicide, and violence. Onset of substance use disorders may begin during childhood, often with alcohol, cannabis, or vaping. Substance use is influenced by peer pressure, family dynamics, trauma, adverse childhood experiences, and emotional dysregulation. Early substance use increases risk for lifelong addiction due to ongoing brain development. Behavioral changes for children using substances may include irritability, truancy, declining grades, secretiveness, withdrawal from family. Risk-taking, mood swings, and impulsivity may be misattributed to “normal adolescence.” Coexisting disorders such as ADHD, anxiety, or depression should be considered. Adolescents need developmentally appropriate, preventive, and early intervention-focused strategies that engage their families and social systems.¹²

11. Simon, K. M., Levy, S. J., & Bukstein, O. G. (2022). Adolescent substance use disorders. *NEJM evidence*, 1(6), EVIDra2200051. <https://doi.org/10.1056/EVIDra2200051>

12. Simon, K. M., Levy, S. J., & Bukstein, O. G. (2022). Adolescent substance use disorders. *NEJM evidence*, 1(6), EVIDra2200051. <https://doi.org/10.1056/EVIDra2200051>

Older Adults

Onset of substance use disorder in older adults may occur due to late-life stressors such as grief, retirement, isolation, or chronic illness. Prescription drug misuse (e.g., opioids, benzodiazepines) is common. Substance use may present with falls, memory loss, confusion, sleep disturbances, or social withdrawal that may be mistaken for dementia symptoms. Older adults require holistic care that integrates mental health, physical health, and social support.¹³

Diagnosis (Analyzing Cues)

A nursing diagnosis related to the abrupt cessation of a psychoactive substance is *Acute Substance Withdrawal Syndrome*. As a syndrome diagnosis, defining characteristics are the related nursing diagnoses, including *Acute Confusion*, *Anxiety*, *Disturbed Sleep Pattern*, *Nausea*, *Risk for Electrolyte Imbalance*, and *Risk for Injury*.¹⁴

- ▶ Review information about syndrome nursing diagnosis in the “[Diagnosis](#)” section of the “Nursing Process” chapter of *Open RN Nursing Fundamentals*.

13. Substance Abuse and Mental Health Services Administration. (2019). Enhancing motivation for change in substance use disorder treatment. *Treatment Improvement Protocol (TIP) Series, No. 35: Chapter 3—Motivational Interviewing as a Counseling Style*. <https://www.ncbi.nlm.nih.gov/books/NBK571068/>
14. Ackley, B., Ladwig, G., Makic, M. B., Martinez-Kratz, M., & Zanoliti, M. (2020). *Nursing diagnosis handbook: An evidence-based guide to planning care* (12th ed.). Elsevier

Outcome Identification (Generate Solutions)

An example of a broad goal related to withdrawal treatment is the following:

- The client will stabilize and remain free from injury.¹⁵

These are some sample SMART outcomes¹⁶ :

- The client's vital signs will remain within normal ranges during treatment.
- The client's electrolyte levels will remain within normal ranges during treatment.
- The client will participate in planning a post-withdrawal treatment program before discharge.

Planning (Generate Solutions)

Safety

Safety receives top priority when planning and implementing interventions for clients with substance use disorder who are at risk of suicide, and interventions are planned according to their level of risk. Review interventions for clients at risk of suicide in the "[Application of the Nursing Process in Mental Health Care](#)" chapter.

15. Ackley, B., Ladwig, G., Makic, M. B., Martinez-Kratz, M., & Zanotti, M. (2020). *Nursing diagnosis handbook: An evidence-based guide to planning care* (12th ed.). Elsevier

16. Ackley, B., Ladwig, G., Makic, M. B., Martinez-Kratz, M., & Zanotti, M. (2020). *Nursing diagnosis handbook: An evidence-based guide to planning care* (12th ed.). Elsevier

Implementation (Take Action)

Nursing Interventions for Substance Use Disorder Based on Categories of the APNA Implementation Standard

Nursing interventions for substance use disorders can be categorized based on the American Psychiatric Nurses Association (APNA) standard for *Implementation* that includes the *Coordination of Care; Health Teaching and Health Promotion; Pharmacological, Biological, and Integrative Therapies; Milieu Therapy; and Therapeutic Relationship and Counseling*. Read more about these subcategories in the “[Application of the Nursing Process in Mental Health Care](#)” chapter. See examples of interventions for each of these categories for clients with anxiety disorders in Table 14.9.

Table 14.9d Examples of Nursing Interventions for Substance Use Disorders by APNA Subcategories^{17, 18}

17. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.
18. National Institute on Drug Abuse. (2023). *Treatment*. <https://nida.nih.gov/research-topics/treatment>

Subcategory of the APNA Standard of Implementation	The nurse will ...	Rationale
Coordination of Care	• Collaborate with a multidisciplinary team (physician, addiction counselor, social worker, pharmacist) to ensure integrated care. • Facilitate referrals to detoxification, rehabilitation, or community recovery programs.	Effective treatment of SUDs requires a collaborative and coordinated approach that addresses medical, psychological, and social needs.
Health Teaching and Health Promotion	• Educate the client on the effects of substance use, including its impact on physical health, mental health, and relationships. • Use motivational interviewing to promote behavior change and harm reduction.	Health education and motivational techniques improve insight, self-efficacy, and readiness for change while reducing relapse risk.

Pharmacological, Biological, and Integrative Therapies	• Administer medications as prescribed (e.g., naltrexone, buprenorphine, acamprosate). • Monitor for withdrawal symptoms, side effects, and adherence. • Incorporate integrative methods such as mindfulness or guided imagery to manage cravings and anxiety.	Medications can support recovery by reducing cravings, preventing relapse, and managing co-occurring conditions. Monitoring ensures safety and promotes therapeutic response.
Milieu Therapy	• Establish a safe, structured, and substance-free environment. • Promote positive peer interaction through group therapy, relapse prevention groups, or 12-step meetings. • Set clear expectations and boundaries.	A therapeutic milieu reduces triggers and access to substances, supports accountability, and promotes recovery-focused behavior.

Therapeutic Relationship and Counseling	• Build a nonjudgmental, empathetic relationship based on trust. • Support client-led goals. • Explore underlying emotional pain, trauma, or mental illness contributing to substance use.	A strong therapeutic alliance improves treatment engagement, reduces shame, and facilitates the exploration of root causes and maladaptive coping.

Nursing Interventions for Physiological Signs of Substance Use Disorder

Nursing interventions also target common physiological signs of substance use disorder and associated self-care deficits. See common interventions for these conditions in Table 14.9e.

Table 14.9e Nursing Interventions Targeting Physiological Signs of Substance Use Disorder and Self-Care Deficit^{19, 20}

19. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

20. National Institute on Drug Abuse. (2023). *Treatment*. <https://nida.nih.gov/research-topics/treatment>

Problem/Intervention	Rationale
Withdrawal • Monitor for withdrawal symptoms using tools such as CIWA-Ar (for alcohol) or COWS (for opioids). • Administer medications (e.g., benzodiazepines, methadone, clonidine) as prescribed. • Provide quiet, low-stimulus environment.	Withdrawal from substances like alcohol or opioids can lead to autonomic instability. Early detection and management of symptoms can prevent complications and mortality.
Nutrition and Hydration • Monitor weight and BMI. • Assess fluid status (I&O, skin turgor, mucous membranes). • Monitor electrolytes and administer replacement therapy as prescribed (e.g., magnesium, potassium). • Encourage oral fluids unless contraindicated. • Provide nutrient-dense meals and snacks. • Administer vitamins (e.g., thiamine, folic acid, multivitamins) as prescribed. • Consult dietitian.	Poor dietary intake, gastrointestinal issues, and dehydration are common in withdrawal. Replenishing nutrition helps restore energy, improve mental clarity. Many individuals with SUD experience electrolyte imbalance, especially during detox. Rehydration can prevent complications like arrhythmias or Wernicke's encephalopathy.
Sleep • Promote sleep hygiene: reduce noise, dim lights, avoid caffeine. • Assess for night sweats, nightmares, or insomnia. • Teach relaxation strategies (e.g., guided breathing, music therapy).	Insomnia is common in withdrawal and early relapse, especially in stimulant and alcohol users. Rest supports emotional and physical recovery.

Pain • Use non-opioid pain relief (e.g., acetaminophen, hot packs, distraction). • Assess for hyperalgesia in opioid users. • Collaborate on safe pain management strategies for clients with SUD and coexisting chronic pain.	Clients with SUD may have altered pain sensitivity due to previous history of poor pain management. Addressing pain promotes trust and recovery adherence.
Elimination • Monitor for nausea, vomiting, diarrhea, or constipation. • Provide antiemetics, fiber supplements, or stool softeners as needed. • Encourage small, frequent meals.	GI symptoms are common during detox and withdrawal. Symptom relief increases treatment tolerability.
Respiratory Status • Assess for respiratory depression, especially with use of opioids or benzodiazepines. • Monitor oxygen saturation and respiratory rate. • Have naloxone available per protocol.	Overdose and sedation are risks with for clients with substance use disorders and nervous system depressants. Vigilant respiratory monitoring is essential for preventing hypoxia or death.
Self-Care Deficits • Assess ability and motivation to perform hygiene, grooming, and ADLs. • Provide structured daily routines and support gradual reengagement with hygiene tasks. • Use positive reinforcement to promote independence.	Individuals with SUD may neglect self-care due to substance use and environmental instability. Supporting ADLs enhances recovery, and reintegration into daily life.

Communication Tips for Clients With Substance Use Disorders

Communicating effectively with someone experiencing a substance use disorder must foster feelings of trust, safety, and therapeutic alliance. People in states of heightened anxiety may struggle to process information, express themselves clearly, or feel emotionally overwhelmed. The following box provides communication tips when speaking with clients with severe anxiety.

Communication Tips for Clients With A Substance Use Disorder²¹

- Use nonjudgmental, person-first language. For example, say “a person with a substance use disorder” instead of “addict” or “alcoholic.”
 - **Rationale:** Person-first language reduces stigma and supports the client’s sense of identity beyond the diagnosis.
- Tailor communication to the client’s stage in the readiness for change model.
 - **Rationale:** Assess where the client is in the **Stages of Change Model (e.g.,**

21. Substance Abuse and Mental Health Services Administration. (2019). Enhancing motivation for change in substance use disorder treatment. *Treatment Improvement Protocol (TIP) Series, No. 35: Chapter 3—Motivational Interviewing as a Counseling Style*. <https://www.ncbi.nlm.nih.gov/books/NBK571068/>

precontemplation, contemplation) and adjust your message accordingly.

- Explore rather than confront denial. For example, instead of saying, “You’re in denial about drinking too much,” ask, “What do you think others are concerned about?” or “What might happen if you continued drinking at this level?”
 - **Rationale:** Using exploratory language maintains rapport while encouraging insight into their behavior.
- Avoid power struggles or ultimatums.
 - **Rationale:** Framing treatment as a collaborative process rather than a directive one encourages cooperation and empowerment, which improves treatment adherence.
- Reflect on their strengths and past successes. For example, highlight what the client has done well or survived in the past (e.g., “You’ve taken steps to come here— that takes courage”)..
 - **Rationale:** Reflecting on strengths and past successes builds self-efficacy, resilience, and motivation.
- Be consistent and set clear, compassionate boundaries.
 - **Rationale:** Setting clear expectations around behavior and attendance help the client feel secure and respected, especially in early recovery.

- Normalize relapse as part of recovery, if it occurs. For example say “Relapse doesn’t mean failure. Let’s figure out what happened and move forward.”.
 - **Rationale:** Relapse is common but doesn’t necessarily mean treatment failure. Normalizing relapse reduces shame and hopelessness.

Withdrawal Treatment

Nursing interventions provide a supportive environment while the client undergoes withdrawal treatment. Vital signs are monitored closely because increases in temperature, pulse, and blood pressure are signs of withdrawal. After ensuring that an individual’s physiological needs of airway, breathing, and circulation are met, safety measures receive top priority. Safety measures during withdrawal treatment may include interventions such as fall precautions, seizure precautions, or implementing restraints as needed to maintain the safety of the individual or those around them.²²

- ▶ Review information on fall precautions in the “[Preventing Falls](#)” section of the “Safety” chapter in *Open RN Nursing Fundamentals, 2e*.

Seizures can occur in clients experiencing alcohol withdrawal. Seizure

22. Halter, M. (2022). *Varcarolis’ foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

precautions include keeping the bed in the lowest position with side rails padded. Suction and oxygen equipment must be available at all times at the client's bedside. Review ANA guidelines on using restraints in the "[Client Rights](#)" section of the "Legal and Ethical Considerations in Mental Health Care" chapter and information on safely implementing restraints in the "[Workplace Violence](#)" section of the "Trauma, Abuse, and Violence" chapter.

Medications are administered as prescribed to keep the client safe and comfortable, so they do not suffer.²³ Review medications used during withdrawal treatment in the "[Withdrawal Management/Detoxification](#)" section of this chapter.

Clients with substance use disorders may exhibit a poor nutritional status due to long-term use of substances taking precedence over food and fluid intake. Nurses provide hydration and gradually reintroduce healthy foods while also promoting rest. Clients with alcohol use disorder are specifically at risk for thiamine (B1) and magnesium deficiencies that can lead to cardiac arrest. Thiamine and other electrolyte replacement is typically included during withdrawal treatment.²⁴

Developing a therapeutic nurse-client relationship can encourage the client to explore harmful feelings of anxiety, hopelessness, and spiritual distress. Encouraging self-care and hygiene helps improve clients' self-esteem.

Nurses educate clients about healthy coping skills and evidence-based treatment and recovery services available in the community.²⁵ Client

23. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.
24. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.
25. Halter, M. (2022). *Varcarolis' foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

education includes understanding the neurobiology behind substance use disorders and the impact on behavior, avoiding triggers, managing cravings, and early warning signs and when to seek help. Family member education includes how to provide emotional support without enabling behavior, family therapy, the importance of boundaries and managing caregiver stress. Review evidence-based treatments and recovery services in the “[Treatment of Substance Use Disorders](#)” section of this chapter.

In addition to implementing the withdrawal treatment plan prescribed by the provider, the nurse collaboratively develops a post-withdrawal treatment plan with interprofessional health care team members. The plan should be client-centered and include their goals and readiness for change. Motivational interviewing is a helpful therapeutic technique when planning individualized treatment goals and programs.²⁶

Evaluation (Evaluate Outcomes)

Evaluation occurs on several levels by assessing the individualized SMART outcomes related to the effectiveness of the withdrawal treatment plan, symptom management, and the client’s readiness and progress towards changes in their behavior.²⁷

Examples of potential evaluation outcomes include:

- Monitor reduction in substance use, improvement in physical and mental health
- Increased engagement in therapy, improved social functioning, employment
- Modify based on client’s progress, address new issues (e.g., relapse, co-

26. Halter, M. (2022). *Varcarolis’ foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

27. Halter, M. (2022). *Varcarolis’ foundations of psychiatric-mental health nursing* (9th ed.). Saunders.

occurring disorders)

- Reinforce coping mechanisms, provide ongoing support

14.10 Spotlight Application

- ▶ This case study is based on a sample client described in the [“Assessment & Treatment of Substance Use Disorders”](#) chapter of the *Foundations of Addiction Studies* book.

Jessica is a 26-year-old woman who recently received her second driving-under-the-influence (DUI) ticket and has been charged with a misdemeanor crime. She received her first DUI at age 21 and lost her license for one year. During that time, she completed a basic risk education DUI course and paid several thousand dollars in fines and attorney's fees.

Jessica continues to drink with her friends on weekends, usually having five or six drinks per night. In addition to alcohol, Jessica was recently prescribed Xanax to treat her anxiety disorder. Jessica often takes more than prescribed in the evening and sometimes mixes these pills with her alcohol consumption.

Jessica works from home full-time as a graphic designer. She says that she has little time to socialize during the week, so she looks forward to the weekend when she can see her friends and relax. Now that she has a second DUI, Jessica has lost her license again, although she is not overly concerned because she can continue working from home. She can walk or order a ride wherever she needs to go for groceries and other errands.

The court has ordered Jessica to have an evaluation done and to complete any treatment recommendations.

Reflective Questions:

1. What were your initial feelings when you read this case study?

2. Can you identify any personal biases or assumptions you experienced while reading this scenario?
3. How many *DSM-5* criteria is Jessica displaying for a substance use disorder diagnosis?
4. List at least three issues to include in a treatment plan for Jessica.
5. How do Jessica's legal issues potentially impact her treatment plan?
6. How will you apply your new knowledge about substance use disorders to your nursing practice?

14.11 Learning Activities



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<https://wtcs.pressbooks.pub/nursingmhcc/?p=875#h5p-47>

1



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2



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2. “MH Substance Use Disorders Drag and Drop” by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)

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<https://wtcs.pressbooks.pub/nursingmhcc/?p=875#h5p-49>

3

- ▶ Test your clinical judgment with an NCLEX Next Generation-style question: [Chapter 14, Assignment 1](#)⁴



- ▶ Test your clinical judgment with an NCLEX Next Generation-style question: [Chapter 14, Assignment 2](#)⁵



3. "MH Substance Use Disorders Question Set 1" by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)
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5. "MH Substance Use Disorders Next Gen Question 2" by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)

- ▶ Test your clinical judgment with an NCLEX Next Generation-style case study: [Chapter 14, Case Study 1](#)⁶



6. “MH Substance Use Disorders Next Gen Case Study” by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)

XIV Glossary

Addiction: Severe substance use disorders are commonly referred to as addiction. Addiction is a chronic brain disease that has the potential for both recurrence (relapse) and recovery.¹

Alcohol intoxication: Refers to problematic behavioral or psychological changes (e.g., inappropriate sexual or aggressive behavior, mood lability, or impaired judgment) that develop during or shortly thereafter alcohol ingestion

Binge drinking: Consuming several standard drinks on one occasion in the past 30 days, defined for males as drinking five or more standard alcoholic drinks on one occasion, and for females as drinking four or more standard drinks on one occasion.²

Brief interventions: Therapeutic techniques used to initiate change in individuals with unhealthy behaviors.

Cannabis intoxication: Problematic behavior or psychological changes (e.g., impaired motor coordination, euphoria, anxiety, sensation of slowed time, impaired judgment, social withdrawal) that developed during or shortly after cannabis use.

Controlled substances: Substances regulated by the U.S. Drug Enforcement Agency into one of five categories called schedules. This placement is based

1. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>
2. National Survey on Drug Use and Health. (2025). *Welcome to the national survey on drug use and health (NSDUH)*. <https://nsduhweb.rti.org/respweb/homepage.cfm>

on the substance's medical use, its potential for abuse or dependency, and related safety issues.

Delirium tremens (DTs): A rapid-onset, fluctuating disturbance of attention and cognition, sometimes associated with hallucinations, due to alcohol withdrawal. In its most severe manifestation, DTs are accompanied by agitation and signs of extreme autonomic hyperactivity, including fever, severe tachycardia, hypertension, and drenching sweats. DTs typically begin between 72 and 96 hours after the client's last drink.

Dependence: A condition that develops with chronic uses of a substance that causes a person to experience withdrawal symptoms if the substance is suddenly stopped.

Drug diversion: The act of redirecting medication from its intended destination for personal use, sale, or distribution to others. It includes drug theft, use, or tampering (adulteration or substitution). Drug diversion is a felony that can result in a nurse's criminal prosecution and loss of license.³

Heavy drinking: Excessive drinking defined as a female consuming 8 or more drinks per week and a male consuming 15 or more standard drinks per week, or either gender binge drinking on 5 or more days in the past 30 days.

Intoxication: A disturbance in behavior or mental function during or after the consumption of a substance.

Neuroadaptations: Progressive changes in the structure and function of the brain as a result of substance misuse. These neuroadaptations compromise brain function and also drive the transition from controlled, occasional substance use to chronic misuse that can be difficult to control.

Nonsubstance related disorders: Excessive behaviors such as gambling, viewing pornography, engaging in compulsive sexual activity, Internet

3. Nyhus, J. (2021). Drug diversion in healthcare. *American Nurse*.
<https://www.myamericannurse.com/drug-diversion-in-healthcare/>

gaming, overeating, shopping, overexercising, and overusing mobile phone technologies. These behaviors are thought to stimulate the same addiction centers of the brain as addictive substances. However, gambling disorder is the only nonsubstance use disorder with diagnostic criteria listed in the *DSM-5*.

Opioid intoxication: A condition where a person is affected by opioid drugs to the point of being impaired and potentially ill.

Protective factors: Factors that help prevent substance use disorders from developing despite the risk factors that are present.

Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Although abstinence from all substance misuse is a primary feature of a recovery lifestyle, it is not the only healthy feature.⁴

Relapse: The return to substance use after a significant period of abstinence.

Remission: The status of individuals with severe substance use disorders who overcome their disorder with effective treatment and regain health and social function.

Standard drink: 14 grams (0.6 ounces) of pure alcohol. Examples of a standard drink are one 12-ounce beer, 8 – 9 ounces of malt liquor, 5 ounces of wine, or 1.5 ounces distilled spirits.

Substance: A psychoactive compound with the potential to cause health and social problems, including substance use disorders. Substances can be divided into four major categories: alcohol, illicit drugs (including nonmedical use of prescription drugs), tobacco products, and over-the-counter drugs.

4. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

Substance misuse: The use of alcohol or drugs in a manner, situation, amount, or frequency that could cause harm to the user or to those around them.⁵

Substance use: The use (even one time) of any psychoactive substance.

Substance use disorder (SUD): A chronic illness caused by repeated misuse of psychoactive substances (e.g., alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics, anxiolytics, stimulants, and tobacco) that have a common effect of directly activating the brain's reward system.

Tolerance: A need for progressively increased amounts of a substance to achieve the desired effect or a diminished effect with continued use of the same amount of a substance.

Withdrawal: A group of physical and mental symptoms that can range from mild to life-threatening when a person suddenly stops using a substance.

Withdrawal management: Interventions that manage the physical and emotional symptoms that occur after a person stops using a psychoactive substance, also referred to as detoxification. Withdrawal symptoms vary in intensity and duration based on the substance(s) used, the duration and amount of use, and the overall health of the individual.

5. Substance Abuse and Mental Health Services Administration, & Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. United States Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK424857/>

Learning Objectives

- Identify assessment cues of clients and families experiencing trauma, abuse, and/or violence
- Identify assessment cues of adverse childhood experiences in a client's history
- Identify factors promoting the cycle of trauma, abuse, and/or violence
- Identify nursing priorities for clients and families experiencing trauma, abuse, and/or violence
- Plan outcomes for clients and families experiencing trauma abuse and/or violence
- Differentiate safety/protective interventions for clients and families experiencing trauma, abuse, and/or violence
- Apply evidence-based practice when planning care and interventions for clients and families experiencing trauma, abuse, and/or violence
- Analyze treatments for clients and families experiencing trauma, abuse, and/or violence
- Apply the nursing process to clients and families experiencing trauma, abuse, and/or violence who are at risk for suicide
- Incorporate trauma-informed care
- Describe strategies to remain safe if workplace violence occurs

The health care system is composed of people who have experienced trauma,

both those providing and those receiving care. Supporters of a trauma-informed care approach recognize the prevalence of trauma survivors within health care settings and are aware that the service setting can also be a source of re-traumatization. As stated in the article *Trauma-Informed Nursing Practice*, understanding how trauma has affected clients' lives and their interactions within the health care system is fundamental to responding to clients' needs and promotes better physical and mental health outcomes.¹

Nurses provide care for clients who are experiencing or have experienced neglect, abuse, and intimate partner violence. In many settings, nurses may experience workplace violence while caring for clients who are agitated or combative. Because these issues are so prevalent, nurses must be knowledgeable of these issues and how to care for afflicted clients. This chapter will discuss adverse childhood experiences and trauma-informed care, abuse and neglect of children and vulnerable adults, intimate partner violence, and workplace violence. Be aware that the content in this chapter may trigger powerful emotions, especially for survivors of similar traumatic experiences. Self-awareness and self-care practices should guide your engagement with this chapter.

- ▶ Read the article “[Trauma-Informed Nursing Practice](#)” in the *Online Journal of Issues in Nursing* published by the American Nurses Association.

1. Fleishman, J., Kamsky, H., & Sundborg, S. (2019). Trauma-informed nursing practice. *OJIN: The Online Journal of Issues in Nursing*, 24(2). <https://doi.org/10.3912/OJIN.Vol24No02Man03>

15.2 Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) refer to traumatic events or circumstances during childhood—including neglect, abuse, witnessing violence, or having a family member with substance abuse, mental illness, divorce, or imprisonment. In the late 1990s, the landmark Adverse Childhood Experiences Study examined over 17,000 participants to assess the long-term impact of these experiences on adult health and behavior. The study revealed that as the number of ACEs increased, children were more likely to develop behavioral problems and engage in risky behaviors during adolescence, such as substance abuse and unprotected sexual activity that could lead to pregnancy. These early-life challenges often set the stage for further health complications later in life. In adulthood, individuals with multiple ACEs were more likely to struggle with substance abuse and suffer from chronic illnesses—including alcoholism, chronic pulmonary disease, depression, and liver disease. Remarkably, those with the highest levels of ACEs had a life expectancy that was, on average, 20 years shorter than that of individuals with few or no ACEs¹ See Figure 15.1² for an infographic of ACEs.

1. [Action steps using ACEs and trauma-informed care: A resilience model](#) by Laurie Leitch is licensed under [CC BY 4.0](#)

2. “ACEs.png” by unknown author for [Centers for Disease Control and Prevention](#) is licensed in the [Public Domain](#). Access for free at https://www.cdc.gov/injury/pdfs/priority/ACEs-Strategic-Plan_Final_508.pdf

Figure 1. What are Adverse Childhood Experiences?

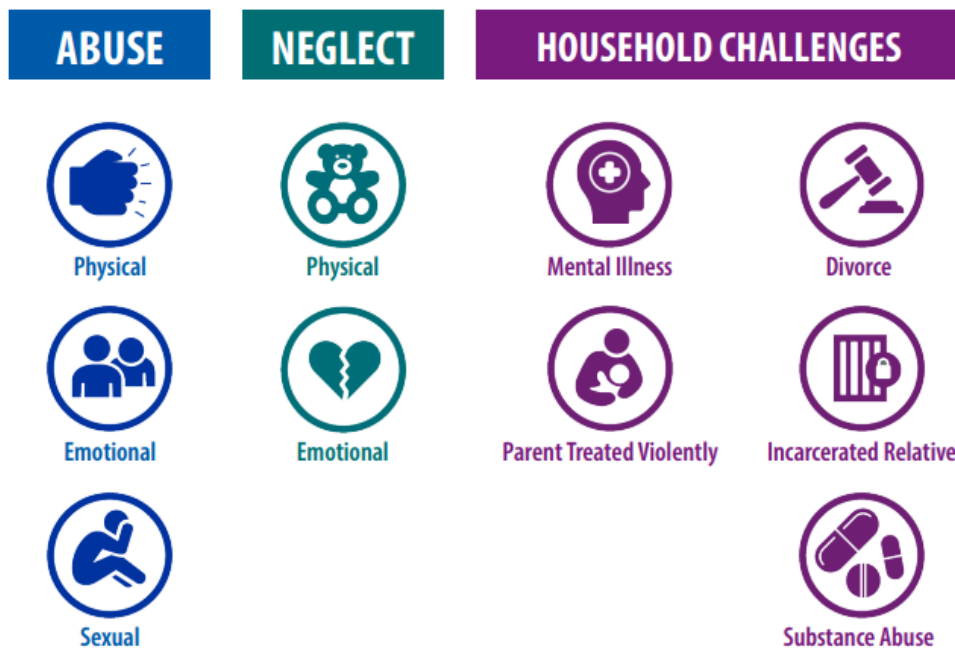


Figure 15.1 Adverse Childhood Events (ACEs)

View the following YouTube video³ on adverse childhood experiences (ACEs), resilience, and trauma-informed care:
 [How childhood trauma affects health across a lifetime | Nadine Burke Harris.](https://youtu.be/95ovIJ3dsNk)

A systematic review and meta analysis in 2024 across demographic characteristics and contexts found that ACEs in children younger than 18 years of age was common, with prevalence of 42% of children having no ACEs, 22% having 1 ACE, 13% having 2 ACEs, 8% having 3 ACEs, and 15% having 4 or

3. TED. (2015, February 17). *How childhood trauma affects health across a lifetime | Nadine Burke Harris*. [Video]. YouTube. All rights reserved.
<https://youtu.be/95ovIJ3dsNk>

more ACEs. The prevalence of 4 or more ACEs was higher among children in residential care, with a history of juvenile offending, and in Indigenous peoples.⁴

View a supplementary YouTube video⁵

While being sensitive to a client's history of trauma and helping support them throughout their life is important, we know that

4. Madigan, S., Thiemann, R., Deneault, A., et al. (2025). Prevalence of adverse childhood experiences in child population samples: A systematic review and meta-analysis. *JAMA Pediatrics*, 179(1), 19–33. [doi:10.1001/jamapediatrics.2024.4385](https://doi.org/10.1001/jamapediatrics.2024.4385)

5. Psych Hub. (2021, November 19). *What is trauma?* [Video]. YouTube. All rights reserved. <https://www.youtube.com/watch?v=q0UPnWfNpak>[/footnote] explaining trauma: [What is Trauma?](#)

For some individuals, traumatic experiences during childhood can cause long term psychological and physical problems due to its impact on the child's developing brain. Various biopsychosocial and cultural factors influence an both immediate and long-term responses to trauma. In most cases, regardless of severity, individuals display resilience—the capacity to overcome adversity and face challenges with determination. This resilience involves mobilizing available resources to navigate hardships and mitigate the impact of adverse events.⁶Center for Substance Abuse Treatment (US). (2014). *Trauma-informed care in behavioral health services*. Substance Abuse and Mental Health Services Administration.

<https://www.ncbi.nlm.nih.gov/books/NBK207201/>

these traumatic experiences are often preventable. Nurses throughout our communities can advocate for improvements, to help promote building positive social relationships and reduce the exposure to violence in children. The Centers for Disease Control and Prevention (CDC) created a resource titled *Preventing Adverse Childhood Experiences (ACEs): Leveraging the Best Available Evidence*. This resource contains these six strategies:

- Strengthen economic supports to families
- Promote
 - social norms that protect against violence and adversity
- Ensure a strong start for children
- Teach skills
- Connect youth to caring adults and activities
- Intervene to lessen immediate and long-term harms

▶ Read about the CDC's prevention strategies in [Adverse Childhood Experiences Prevention: Resource for Action PDF](#).

▶ View the following CDC YouTube video on adverse



childhood experiences and protective factors⁷: We Can Prevent ACEs.

Risk Factors, Protective Factors, and Prevention Strategies

By bringing attention to the powerful impact that negative childhood experiences have on future health and functioning, the ACE study demonstrates the importance of designing early intervention programs that target abuse, neglect, and violence.⁸ Nurses can help prevent ACEs by educating parents, communities, and policymakers about how to help families provide safe and stable environments for children.

Many factors contribute to ACEs, including personal traits and experiences, parents, the family environment, and the community itself. ACEs can have lasting negative effects on health and well-being, but these harms can be preventable. To prevent ACEs and protect children from neglect, abuse, and

7. Centers for Disease Control and Prevention (CDC). (2018, April 5). *We can prevent ACEs*. [Video]. YouTube. All rights reserved. <https://youtu.be/8gm-INpzU4g>

8. Center for Substance Abuse Treatment (US). (2014). *Trauma-informed care in behavioral health services*. Substance Abuse and Mental Health Services Administration. <https://www.ncbi.nlm.nih.gov/books/NBK207201/>

violence, nurses are involved in addressing these risk factors and protective factors with prevention strategies.⁹

Appropriately addressing traumatic experiences and promoting resilience are important parts of effective mental health care and integral for the healing and recovery process.¹⁰

Risk Factors

Risk factors are conditions that increase the likelihood of experiencing ACEs. There are individual, family, and community risk factors for ACEs.

INDIVIDUAL AND FAMILY RISK FACTORS

Individual and family risk factors include the following¹¹:

Individual:

- Children and adolescents who don't feel close to their parents/caregivers or feel they can't talk to them about their feelings
- Youth who start dating or engaging in sexual activity at an

9. Centers for Disease Control and Prevention. (2024). *Risk and protective factors*. <https://www.cdc.gov/aces/risk-factors/index.html>

10. Substance Abuse and Mental Health Services Administration. (2022). *Trauma and violence*. <https://www.samhsa.gov/trauma-violence>

11. Centers for Disease Control and Prevention. (2024). *Risk and protective factors*. <https://www.cdc.gov/aces/risk-factors/index.html>

early age

- Children and youth with few or no friends or with friends who engage in aggressive or delinquent behavior

Families experiencing:

- Caregiving challenges related to children with special needs (e.g., disabilities, mental health issues, chronic illnesses)
- High levels of stress from parenting or economic issues
- Isolation from extended family, friends, or neighbors

Families with caregivers who:

- Have a limited understanding of children's needs or development
- Were abused or neglected as children
- Are young or single parents

Families with:

- Low income or low levels of adult education
- High conflict and negative communication styles
- Attitudes accepting of or justifying violence or aggression
- Inconsistent discipline, corporal punishment, and/or low parental supervision

COMMUNITY RISK FACTORS

Communities with ¹²:

12. Centers for Disease Control and Prevention. (2024). *Risk and protective factors*. <https://www.cdc.gov/aces/risk-factors/index.html>

- High rates of violence and crime
- Limited educational and economic opportunities
- High rates of poverty, unemployment rates, and food insecurity
- Easy access to drugs and alcohol
- Low community involvement among residents
- Few community activities for youth
- Unstable housing where residents move frequently

Protective Factors

Protective factors help reduce the likelihood of ACEs and support resilience.

INDIVIDUAL AND FAMILY PROTECTIVE FACTORS

Individual and family protective factors against ACEs include the following ¹³:

Children who:

- Have positive friendships and peer networks
- Experience academic success
- Have caring adults outside the family as mentors/role models

Families where caregivers:

- Can meet children's basic needs (food, shelter, health

¹³. Centers for Disease Control and Prevention. (2024). *Risk and protective factors*. <https://www.cdc.gov/aces/risk-factors/index.html>

services)

- Create a stable, supportive home with nurturing relationships
- Engage in positive parenting with consistent rules and supervision
- Help children work through problems and resolve conflicts peacefully
- Encourage the importance of school and academic success
- Have strong social support networks and positive relationships

Families with:

- Caregivers who have higher education or steady employment
- Fun, positive activities that strengthen family bonds

COMMUNITY PROTECTIVE FACTORS

Communities can intervene to lessen the harms from ACEs and prevent future risks.

Communities where^{14 15}:

- Families have access to education and support regarding

14. Centers for Disease Control and Prevention. (2024). *Risk and protective factors*. <https://www.cdc.gov/aces/risk-factors/index.html>

15. Centers for Disease Control and Prevention (CDC). (2018, April 5). *We can prevent ACEs*. [Video]. YouTube. All rights reserved. <https://youtu.be/8gm-INpzU4g>

positive parenting

- Families have access to economic and financial help
- Families have access to medical care and mental health services
- Individuals and families have access to safe, stable housing
- Families have access to nurturing and safe child care
- Families have access to high-quality preschool programs
- Families have access to safe, engaging after-school programs and activities
- Adults have work opportunities with family-friendly policies
- There are strong partnerships among the community and business, health care, government, and other sectors
- Residents feel connected to each other and are involved in the community
- Violence is not tolerated or accepted in the community
- Positive parenting strategies are social norms in the community

15.3 Trauma-Informed Care

Trauma has no age, gender, socioeconomic status, race, ethnicity, or sexual orientation boundaries. **Individual trauma** results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and can have lasting adverse effects on their functioning and mental, physical, social, emotional, or spiritual well-being. Adverse childhood experiences (ACEs) are examples of individual traumas.¹

The body's physiological stress response, known as “fight, flight, freeze, or fawn” is an automatic survival mechanism triggered by the sympathetic nervous system (SNS) when a threat is perceived. This response activates multiple organs, leading to symptoms such as increased heart rate, elevated blood pressure, rapid breathing, and muscle tension.²

- ▶ Review the physiology of the sympathetic nervous system and the parasympathetic nervous system in the “[Psychotropic Medications](#)” chapter.
- ▶ Review activation of the stress response in the “[Stress, Coping, and Crisis Intervention](#)” chapter.

Repeated exposure to ACEs can prolong this heightened stress response, rewiring the brain's physiological reactivity and impairing emotional

1. [Action steps using ACEs and trauma-informed care: A resilience model](#) by Laurie Leitch is licensed under [CC BY 4.0](#)
2. [Action steps using ACEs and trauma-informed care: A resilience model](#) by Laurie Leitch is licensed under [CC BY 4.0](#)

regulation. This can contribute to depression, anxiety, substance use, chronic physical and mental illnesses, and increased suicide risk. Chronic stress can also reduce positive social behaviors, such as collaboration and kindness, as cognitive resources are diverted toward survival responses.³

Arousal and reactivity symptoms include the following⁴:

- Being easily startled
- Feeling tense or “on edge”
- Having difficulty sleeping
- Having angry outbursts

These symptoms can make the person feel stressed and angry and can make it hard to do daily tasks, such as sleeping, eating, or concentrating.⁵

Individuals who have a history of trauma may become triggered by engagement with the health care system. They may experience arousal and reactivity symptoms. As a result of the stimulation of the “fight, flight, freeze, or fawn” stress response, the parts of the brain involved in memory, planning, decision-making, and regulation are not engaged. This can impact the client’s involvement with health care services and affect their ability to adhere to

3. Trauma-Informed Care Implementation Resource Center. (n.d.). *What is trauma-informed care?* Center for Health Care Strategies. <https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/>
4. National Institute of Mental Health. (2019). *Post-traumatic stress disorder*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd>
5. National Institute of Mental Health. (2019). *Post-traumatic stress disorder*. U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd>

treatment plans.⁶ Nurses must understand this potential impact of previous trauma and incorporate client-centered, trauma-informed care.

Trauma-informed care is an approach that uses a lens of trauma to understand the range of cognitive, emotional, physical, and behavioral symptoms seen when individuals enter health care systems. **Trauma-informed care (TIC)** is a strengths-based framework that acknowledges the prevalence and impact of traumatic events in clinical practice, placing an emphasis on instilling in clients a sense of safety, control, and autonomy over their life and health care decisions. The basic goals of TIC are to avoid re-traumatization; emphasize survivor strengths and resilience; aid empowerment, healing, and recovery; and promote the development of survivorship skills.⁷

Two influential studies set the stage for the development of TIC⁸:

- The Adverse Childhood Experiences Study was an extensive study involving more than 17,000 individuals from the United States. It analyzed the long-term effects of childhood and adolescent traumatic experiences on adult health risks, mental health, health care costs, and life expectancy.⁹

6. Fleishman, J., Kamsky, H., & Sundborg, S. (2019). Trauma-informed nursing practice. *OJIN: The Online Journal of Issues in Nursing*, 24(2). <https://doi.org/10.3912/OJIN.Vol24No02Man03>
7. Tracy, E. E., & Macias-Konstantopoulos, W. (2021). Human trafficking: Identification and evaluation in the health care setting. *UpToDate*. www.uptodate.com
8. Center for Substance Abuse Treatment (US). (2014). *Trauma-informed care in behavioral health services*. <https://www.ncbi.nlm.nih.gov/books/NBK207201/>
9. Felitti, V. J., Anda, R. F., Nordenberg, D., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many

- The Women, Co-Occurring Disorders, and Violence Study was a study focused on the role of interpersonal and other traumatic stressors among women. The researchers examined the interrelatedness of trauma, violence, and co-occurring substance use and mental health disorders and the incorporation of trauma-informed services.¹⁰

The Substance Abuse and Mental Health Services Administration (SAMHSA) has defined six core principles of TIC. See Figure 15.2¹¹ for an infographic related to these principles¹²:

- **Safety:** Throughout the organization, clients and staff feel physically and psychologically safe.
- **Trustworthiness and Transparency:** Decisions are made with transparency and with the goal of building and maintaining trust.
- **Peer Support:** Individuals with shared experiences are integrated into the organization and viewed as integral to service delivery.
- **Collaboration and Mutuality:** Power differences between staff and clients and among organizational staff are leveled to support shared decision-

of the leading causes of death in adults: The adverse childhood experience (ACE) study. *American Journal of Preventive Medicine*, 14(3), 245-258.
[https://doi.org/10.1016/S0749-3797\(98\)00017-8](https://doi.org/10.1016/S0749-3797(98)00017-8)

10. Clark, H. W., & Power, A. K. (2005). Women, co-occurring disorders, and violence study: A case for trauma-informed care. *Journal of Substance Abuse Treatment*, 28(2), 145-146. <https://doi.org/10.1016/j.jsat.2005.01.002>
11. This image is a derivative of “training_emergency_responders_final.jpg” by [Centers for Disease Control and Prevention](#) and in the [Public Domain](#). Access for free at https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm
12. Trauma-Informed Care Implementation Resource Center. (n.d.). *What is trauma-informed care?* Center for Health Care Strategies. <https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/>

making.

- **Empowerment Voice and Choice:** Client and staff strengths are recognized, built on, and validated, including a belief in resilience and the ability to heal from trauma.
- **Cultural, Historical, and Gender Issues:** Biases and stereotypes (e.g., based on race, ethnicity, sexual orientation, age, geography) and historical trauma are recognized and addressed.



Figure 15.2 Core Principles of Trauma-Informed Care



View the following YouTube video on ACEs and trauma-informed care¹³: [What is Trauma-Informed Care?](https://youtu.be/fWken5DsJcw)

Trauma-Informed Nursing Practice

Nurses can incorporate trauma-informed care by routinely implementing the following practices with all clients¹⁴:

13. Center for Health Care Strategies. (2019, January 23). *What is trauma-informed care?* [Video]. YouTube. All rights reserved. <https://youtu.be/fWken5DsJcw>
14. Fleishman, J., Kamsky, H., & Sundborg, S. (2019). Trauma-informed nursing practice. *OJIN: The Online Journal of Issues in Nursing*, 24(2). <https://doi.org/10.3912/OJIN.Vol24No02Man03>

- **Introduce Yourself and Your Role in Every Client Interaction:** Clients may recognize you, but they may not remember your role. This may lead to confusion and misunderstanding. When a client understands who you are and your role in their care, they feel empowered to be actively engaged in their own care. They also feel less threatened because they know your name and why you are interacting with them. When one party is nameless, there can be an automatic power differential in the interaction.
- **Use Open and Nonthreatening Body Positioning:** Be aware of your body position when working with clients. Open body language conveys trust and a sense of value. Trauma survivors often feel powerless and trapped. Health care situations can trigger past experiences of lack of control or an inability to escape. Using nonthreatening body positioning helps prevent the threat detection areas of the client's brain from taking over and helps clients stay regulated. A trauma-informed approach to body position includes attempting to have your body on the same level as the client, often sitting at or below the client. It could also include raising a hospital bed in order for the nurse and the client to be on the same level, reducing the likelihood of creating a perceived power differential through positioning. Additionally, it is important to think about where you and the client are positioned in the room in relation to the door or exit. Both nurse and client should have access to the exit so that neither feels trapped.
- **Provide Anticipatory Guidance:** Verbalize what the client can expect during a visit or procedure or what paperwork will cover. Knowing what to expect can reassure clients even if it is something that may cause discomfort. Past trauma is often associated with unexpected and unpredictable events. Knowing what to expect reduces the opportunity for surprises and activation of the SNS symptoms. It also helps clients feel more empowered in the care planning process.
- **Ask Before Touching:** For many trauma survivors, inappropriate or unpleasant touch was part of a traumatic experience. Touch, even when appropriate and necessary for providing care, can trigger a “fight, flight,

freeze or fawn” response and bring up difficult feelings or memories. This may lead to the individual experiencing increased anxiety and activation of the stress response, resulting in disruptive behaviors and possible dissociation. **Dissociation** is a break in how a person’s mind handles information, causing disconnection from their thoughts, feelings, memories, and surroundings. Nurses are often required to touch clients, and sometimes this touch occurs in sensitive areas. Any touch can be interpreted as unwanted or threatening, so it is important to ask all clients permission to touch them. Asking permission before you touch clients gives them a choice and empowers them to have control over their body and physical space. Be alert to nonverbal signs such as eye tearing, flinching, shrinking away, or other body language indicating the person is feeling uncomfortable. If the client exhibits signs of discomfort when being touched, additional nursing interventions can be implemented such as a mindfulness or grounding practice.

- **Protect Client Privacy:** Family members and other members of the medical team may be present when you care for a client. Clients may not feel empowered or safe in asking others to step out. It is crucial that nurses do not put the responsibility on the client to ask others to leave. It is the nurse’s role to ask the client (in private) whom they would like to be present during care and ask others to leave the room.
- **Provide Clear and Consistent Messaging About Services and Roles:** Trust is built when clients experience care providers who are forthright and honest. Dependability, reliability, and consistency are important when working with trauma survivors because previous trauma was often unexpected or unpredictable. Providing consistency from the nursing team regarding expectations and/or hospital rules can help clients feel secure and decrease opportunities for unmet expectations that might lead to triggering disruptive behavior.
- **Use Plain Language and Teach Back:** Avoid medical jargon and use clear, simple language. When clients are feeling triggered (i.e., their “fight, flight, freeze or fawn” system is engaged), information processing and

learning parts of the brain do not function optimally, and it is hard to remember new information. When providing education, information, or instructions, break information into small chunks and check for understanding. Offer to write important details down so they can accurately recall the information at a later time. Use clear language and “teach back” methods that empower clients with knowledge and understanding about their care.

- **Practice Universal Precaution:** Universal precaution means providing TIC to all clients regardless of a trauma history. Although ACE screening may be part of routine care, it can also have potential negative effects on clients. Unless a trauma-focused intervention is needed to amend the impact of trauma, many TIC experts propose universal precaution rather than direct screening.

▶ Read a continuing education article titled “[Trauma-Informed Nursing Practice](#)” in the *American Journal of Nursing*.¹⁵

Post-traumatic stress disorder (PTSD) is diagnosed in individuals who have been exposed to a traumatic event with chronic stress symptoms lasting more than one month that are so severe they

¹⁵. Dowdell, E., & Speck, P.M. (2022). Trauma-informed care in nursing practice. *American Journal of Nursing*, 122(4), 30-38.
https://journals.lww.com/ajnonline/Fulltext/2022/04000/CE_Trauma_Informed_Care_in_Nursing_Practice.22.aspx

interfere with relationships, school, or work. Read more about PTSD in the “[Anxiety Disorders](#)” chapter.

The Resilient Zone and Self-Regulation Skills

Individuals who have experienced repetitive or cumulative trauma may develop a dysregulated rhythm of their sympathetic nervous system (SNS) and parasympathetic nervous system (PNS), leaving them reactive and stuck in a state of hyperarousal, hypoarousal, or oscillating between the two extremes as their nervous system attempts to find balance. Simply put, the SNS “activates” the stress response, and the PNS “calms” the stress response. When out of balance, individuals may exhibit behaviors such as substance use disorders, self-harming, violence, poor school and work performance, bullying, and social disengagement.¹⁶ Nurses can teach clients self-regulation skills by paying attention to their “fight, flight, or freeze” symptoms and learning how to balance their SNS and PNS systems.

Self-regulation skills teach clients how to return to a healthy balance of SNS and PNS stimulation called the resilient zone. See Figure 15.3¹⁷ for an illustration of the **resilient zone** when the SNS and PNS are in balance. When in the resilient zone, the hormones released by the SNS during the “fight, flight, or freeze” stress response do not block conscious information processing by the brain. This balance promotes better capacity for flexibility

16. [Action steps using ACEs and trauma-informed care: A resilience model](#) by Laurie Leitch is licensed under [CC BY 4.0](#)

17. Leitch, L. (2017). Action steps using ACEs and trauma-informed care: A resilience model. *Health Justice* 5, 5. <https://doi.org/10.1186/s40352-017-0050-5>

and adaptability, prosocial behavior, improved problem-solving, and strategic thinking.¹⁸

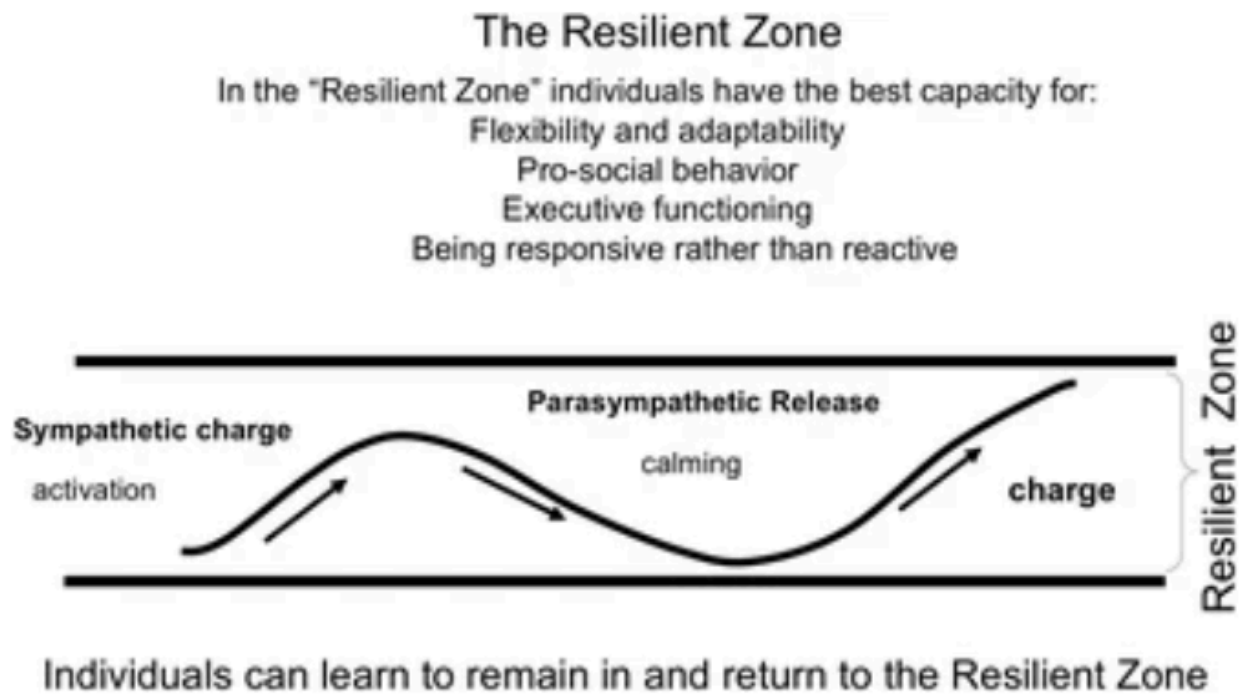


Figure 15.3 The Resilient Zone

Teaching self-regulation skills enables the individual to pay attention to symptoms of the stress response and use techniques to purposefully stimulate the PNS. They focus on quality of breath, heart rate, and muscle tension and then use relaxation breathing, progressive muscle relaxation, meditation, or other methods to stimulate the PNS. These skills can be used prior to and during challenging events, as well as practiced over time to build deeper nervous system balance.¹⁹

18. [Action steps using ACEs and trauma-informed care: A resilience model](#) by Laurie Leitch is licensed under [CC BY 4.0](#)

19. [Action steps using ACEs and trauma-informed care: A resilience model](#) by Laurie Leitch is licensed under [CC BY 4.0](#)

- ▶ Read more about stress management, self-regulation skills, and grounding techniques in the “[Stress, Coping, and Crisis Intervention](#)” chapter.

15.4 Abuse and Neglect

Child Neglect and Abuse

All 50 states and the District of Columbia have child abuse and neglect reporting laws that mandate certain professionals and institutions refer suspected maltreatment to a Child Protective Services (CPS) agency. Each state has its own definitions of child abuse and neglect that are based on standards set by federal law. Federal legislation defines child abuse and neglect as, “Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act, which presents an imminent risk of serious harm.”¹ In 2019 there were 656,000 victims of child abuse and neglect, with a victim rate calculated as 9 victims per 1,000 children across the United States. In addition, 74.9 percent of victims were neglected, 17.5 percent were physically abused, and 9.3 percent were sexually abused. Child fatalities are the most tragic consequence of maltreatment. In 2019 it was estimated that 1,840 children died from abuse and neglect in the United States. The youngest children are the most vulnerable to maltreatment, with 45.4 percent of child fatalities younger than 1 year old. A perpetrator is the person who is responsible for the abuse or neglect of a child. Furthermore, 77.5% of perpetrators are a parent of the victim.²

An organization called A Safe Haven for Newborns is dedicated to preventing

1. Administration for Children & Families. (2021). *Child maltreatment 2019*. [Report]. U.S. Department of Health & Human Services.
<https://www.acf.hhs.gov/cb/report/child-maltreatment-2019>
2. Administration for Children & Families. (2021). *Child maltreatment 2019*. [Report]. U.S. Department of Health & Human Services.
<https://www.acf.hhs.gov/cb/report/child-maltreatment-2019>

infant abuse and abandonment through education, prevention, and direct assistance (see Figure 15.4³).

- ▶ Call the Safe Haven Helpline at 1-877-440-2229 or visit the [A Safe Haven for Newborns](https://asafehavenfornewborns.com) website to find local resources.

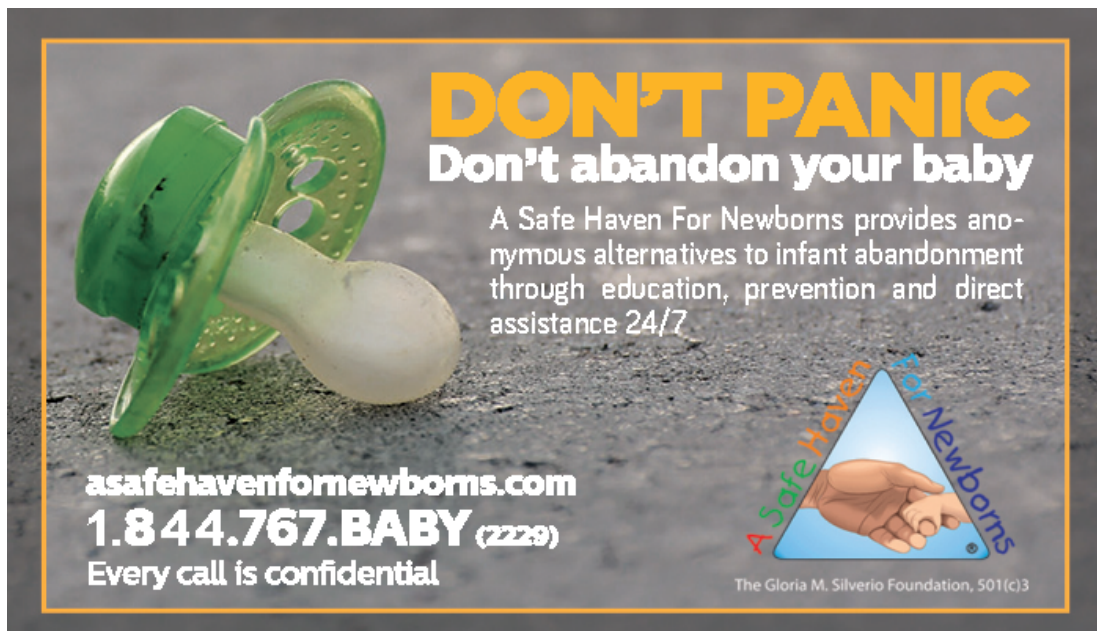


Figure 15.4 A Safe Haven For Newborns. Used under Fair Use.

3. "bc-english-ashfnb" by [A Safe Haven for Newborns](https://asafehavenfornewborns.com) is used under Fair Use. Access for free at <https://asafehavenfornewborns.com/international-safe-haven/>

Assessment

Signs of Neglect and Abuse

NEGLECT

Neglect is a situation in which a parent or caretaker fails, refuses, or is unable, for reasons other than poverty, to provide the necessary care, food, clothing, or medical or dental care, which seriously endangers the physical, mental, or emotional health of the child. Signs of child neglect include the following⁴:

- Exhibits poor hygiene or body odor
- Is inappropriately dressed for weather
- Demonstrates needed medical or dental care
- Is left alone unsupervised for long periods of time
- Appears malnourished
- Is constantly hungry or begs for or steals food
- Demonstrates exhibits extreme willingness to please
- Is frequently absent from school
- Arrives early and stays late at school, play areas, or other people's home

PHYSICAL ABUSE

Physical abuse is defined as injury inflicted on a child by other than accidental means. Physical injury includes, but is not limited to, lacerations, fractured bones, burns, internal injuries, severe or frequent bruising, or great bodily harm. Signs of physical abuse in children are as follows⁵:

4. Wisconsin Department of Children and Families. (n.d.). *Signs of child abuse and neglect*. <https://dcf.wisconsin.gov/cps/signs>
5. Wisconsin Department of Children and Families. (n.d.). *Signs of child abuse and neglect*. <https://dcf.wisconsin.gov/cps/signs>

- Bruises and/or welts on face, neck, chest, back, or soft muscle areas less prone to bruising by natural play or accidents (e.g., abdomen, breasts, under arm, inner thigh)
- Injuries in the shape of object (e.g., belt or cord)
- Unexplained burns on palms, soles of feet, or back; a line of demarcation from submerging in hot liquids (e.g., ankles, buttocks, wrists); burns in the shape of object (e.g., fork, cigarette)
- Fractures that do not fit the story of how an injury occurred
- Delay in seeking medical help
- Extremes in behavior (e.g., very aggressive or withdrawn and shy)
- Afraid to go home
- Frightened of parents
- Fearful of other adults
- Failure to thrive

However, some injuries are not visible to observation, such as shaken baby syndrome, a serious brain injury resulting from forcefully shaking an infant or toddler.

SEXUAL ABUSE

Sexual abuse is defined as sexual intercourse or sexual touching of a child; sexual exploitation; human trafficking of a child; forced viewing of sexual activity; or permitting, allowing, or encouraging a child to engage in prostitution. Here are signs of sexual abuse in children⁶:

- Pain, swelling, or itching in genital area
- Bruises, bleeding, discharge in genital area
- Difficulty walking or sitting, frequent urination, or pain
- Stained or bloody underclothing
- Sexually transmitted diseases

6. Wisconsin Department of Children and Families. (n.d.). *Signs of child abuse and neglect*. <https://dcf.wisconsin.gov/cps/signs>

- Refusal to take part in gym or other exercises
- Poor peer relationships
- Unusual interest in sex for age
- Drastic change in school achievement
- Runaway or delinquent behavior
- Regressive to behaviors expected for a younger child

► Read additional information about human trafficking in the “[Vulnerable Populations](#)” chapter.

EMOTIONAL ABUSE

Emotional abuse is defined as harm to a child’s psychological or intellectual functioning, which is exhibited by severe anxiety, depression, withdrawal, or aggression. Emotional damage may be demonstrated by substantial and observable changes in behavior, emotional response, or learning that are incompatible with the child’s age or stage of development. Signs of emotional abuse in children include the following⁷:

- Low self-esteem
- Self-denigration
- Severe depression
- Unusual level of aggression
- Severe anxiety
- Extreme withdrawal
- Failure to learn

7. Wisconsin Department of Children and Families. (n.d.). *Signs of child abuse and neglect*. <https://dcf.wisconsin.gov/cps/signs>

Interventions

Effective interventions are essential to ensure child safety, stop the abuse, support recovery, and prevent future harm. Interventions typically begin with immediate protective actions and extend into medical, psychological, legal, and family-centered care.

When abuse is suspected, professionals such as nurses, educators, and social workers (who are often mandated reporters) must report their concerns to local child protective services (CPS). Child Protective Services (CPS) agencies provide services to children and their families, both in their homes and in foster care. Services are provided to prevent future instances of child maltreatment and remedy conditions that brought the children and their family to the attention of the agency.⁸ Once a report is made, CPS investigates the claim, assesses the level of risk, and determines the need for protective measures. In cases of immediate danger, children may be removed from their homes and placed in temporary foster or kinship care. Forensic interviews are often conducted in child advocacy centers by trained professionals using trauma-informed techniques to gather accurate and sensitive information without re-traumatizing the child.

Following the initial response, children may require medical attention to treat injuries or address physical health concerns. Pediatric healthcare providers, especially those trained in child maltreatment, play a crucial role in identifying signs of abuse and initiating appropriate referrals. Mental health interventions are also essential. **Trauma-focused cognitive behavioral therapy (TF-CBT)** is widely recognized as an evidence-based treatment that helps children process trauma, develop coping skills, and reduce symptoms of

8. Administration for Children & Families. (2021). *Child maltreatment 2019*. [Report]. U.S. Department of Health & Human Services.
<https://www.acf.hhs.gov/cb/report/child-maltreatment-2019>

anxiety, depression, or post-traumatic stress.⁹ Family therapy may be introduced if reunification with parents or guardians is a possibility, promoting healing and restoring healthy family relationships.

Ongoing support often includes case management and access to family-centered services. Parenting programs and home visiting initiatives, such as the Nurse-Family Partnership, aim to improve caregiver skills, reduce stress, and create safer home environments. These supports are especially beneficial in preventing recurrence of abuse. Social workers and case managers work closely with families to coordinate services, monitor progress, and ensure adherence to safety plans.

Legal involvement is another critical element. Family courts make determinations about custody, visitation, and parental rights, while criminal courts address charges against abusers. Guardians ad litem (GALs) or court-appointed special advocates (CASAs) may be assigned to represent the child's best interests in these proceedings. The legal process can be daunting for families and children, which is why coordination between legal and mental health professionals is vital to minimize additional trauma.

A multidisciplinary team (MDT) approach enhances the effectiveness of child abuse interventions. This collaborative model brings together healthcare providers, mental health specialists, law enforcement, educators, and child welfare workers to share information, streamline care, and ensure the child receives comprehensive, holistic support. MDTs often meet at child advocacy centers or through coordinated local systems to address cases in a child-centered and trauma-informed manner.

Importantly, interventions must be tailored to the child's age, developmental stage, and cultural background. Cultural humility and developmental sensitivity help build trust with families and ensure that services are both respectful and effective. Interventions that are culturally responsive and

9. Medical University of South Carolina. (n.d.). *TF-CBT Web: Trauma-focused cognitive behavioral therapy training*. <https://www.tfcbt.org>

developmentally appropriate have been shown to reduce disparities in care and promote engagement with services.

Neglect and Abuse of Older Adults and Adults at Risk

Elder abuse is a common problem in the United States. Abuse, including neglect and exploitation, is experienced by about 1 in 10 people aged 60 and older who live at home. From 2002 to 2016, more than 643,000 older adults were treated in the emergency department for nonfatal assaults, and over 19,000 homicides occurred. This information is considered an underestimate of the problem because it is limited to those individuals treated in emergency departments and doesn't include those who do not seek treatment. Victims must decide whether to tell someone they are being hurt or continue being abused by someone they depend upon or care for deeply.¹⁰

Elder abuse is defined as an intentional act or failure to act that causes or creates a risk of harm to an older adult. An older adult is defined as someone age 60 or older.¹¹ Adults at risk are also considered vulnerable adults at risk for abuse. **Adults at risk** are defined as adults who have a physical or mental condition that impairs their ability to care for their own needs.¹² Older adults and adults at risk are potentially susceptible for abuse, neglect, or financial exploitation by caregivers or a person they trust.¹³ A **caregiver** is a person who has taken responsibility for all or part of an individual's care. Risk factors for

10. Centers for Disease Control and Prevention. (2024). *About abuse of older persons*. <https://www.cdc.gov/elder-abuse/about/index.html>

11. Centers for Disease Control and Prevention. (2024). *About abuse of older persons*. <https://www.cdc.gov/elder-abuse/about/index.html>

12. Wisconsin Department of Health Services. (2018). *Adult protective services: Definitions*. <https://www.dhs.wisconsin.gov/aps/definitions.htm#Abuse>

13. Centers for Disease Control and Prevention. (2024). *About abuse of older persons*. <https://www.cdc.gov/elder-abuse/about/index.html>

elder abuse include cognitive impairment, functional dependency, poor physical health, low income, social isolation, and a history of past trauma or abuse. Perpetrator-related risk factors include caregiver burden, psychiatric illness, and substance abuse. Environmental factors such as living in high-crime areas and low social support also contribute to the risk.¹⁴

The following are types of elder abuse¹⁵:

- **Physical abuse:** Physical abuse refers to illness, pain, injury, functional impairment, distress, or death as a result of the intentional use of physical force and includes acts such as hitting, kicking, pushing, slapping, and burning. See Figure 15.5¹⁶ for an infographic describing physical signs of elder abuse.
- **Sexual abuse:** Sexual abuse refers to forced or unwanted sexual interaction of any kind. This may include unwanted sexual contact or penetration or non-contact acts such as sexual harassment.
- **Emotional abuse:** Emotional abuse refers to verbal or nonverbal behaviors that inflict anguish, mental pain, fear, or distress, such as humiliation or disrespect, verbal and nonverbal threats, harassment, and geographic or interpersonal isolation.
- **Neglect:** Neglect is the failure to meet the person's basic needs, including food, water, shelter, clothing, hygiene, and essential medical care.
- **Financial abuse:** Financial abuse is the illegal, unauthorized, or improper

14. Johannesen, M. & LoGiudice, D. (2013). Elder abuse: a systematic review of risk factors in community-dwelling elders. *Age Ageing*, 42(3), 292-8. [doi: 10.1093/ageing/afs195](https://doi.org/10.1093/ageing/afs195).

15. Centers for Disease Control and Prevention. (2024). *About abuse of older persons*. <https://www.cdc.gov/elder-abuse/about/index.html>

16. "Signs of Elder Abuse – Physical" by National Council on Aging is used under Fair Use. Access for free at <https://www.ncoa.org/article/get-the-facts-on-elder-abuse>

use of money, benefits, belongings, property, or assets for the benefit of someone other than the individual.

- **Treatment without consent:** Treatment without consent refers to the administration of medication or the performance of psychosurgery, electroconvulsive therapy, or experimental research on an individual who has not provided informed consent.
- **Unreasonable confinement or restraint:** Unreasonable confinement or restraint refers to the intentional and unnecessary confinement of an individual in a locked room, involuntary separation from their living area, use of physical restraints, or the provision of unnecessary or excessive medication. (This does not include the use of these methods or devices if they conform with state and federal standards governing restraint or seclusion. Review ANA guidelines on using restraints in the “[Client Rights](#)” section of the “Legal and Ethical Considerations in Mental Health Care” chapter.)

Assessment

Elder abuse can be challenging to detect, as symptoms may be subtle or mistaken for age-related conditions. A comprehensive assessment involves careful observation, open-ended questioning, and consideration of both physical and psychosocial indicators. Clinicians should maintain a high index of suspicion, especially when inconsistencies arise between reported histories and observed findings.

Physical indicators may include unexplained injuries such as bruises, lacerations, burns, or fractures. Particular attention should be paid to injury patterns that are inconsistent with normal aging or accidental trauma. For instance, bruising on the maxillofacial area, upper extremities (especially the inner arms), or torso may suggest defensive injuries or restraint use. Recurrent injuries at various stages of healing are also red flags. In cases of

sexual abuse, assess for genital trauma, sexually transmitted infections, or sudden behavioral changes.^{17,18}

Behavioral and psychological signs can include withdrawal, increased anxiety, depression, agitation, or fear of specific individuals—especially caregivers. A once-outgoing elder who becomes socially isolated or unusually quiet during interactions may be experiencing emotional or psychological abuse.^{19,20}

Neglect-related signs are equally important and may present as poor hygiene, untreated medical conditions, malnutrition, dehydration, pressure injuries, or inappropriate clothing for the weather. Weight loss without a medical cause or a dirty, unsafe living environment may also be indicative of neglect.^{21,22}

Healthcare utilization patterns may offer additional clues. Frequent emergency department visits, inconsistent follow-up care, or evidence of

17. National Center on Elder Abuse (NCEA). (2020). *Types and signs of abuse*. U.S. Department of Health & Human Services. <https://ncea.acl.gov>
18. Lachs, M. S., & Pillemer, K. A. (2015). Elder abuse. *The New England Journal of Medicine*, 373(20), 1947–1956. <https://doi.org/10.1056/NEJMr1404688>
19. National Center on Elder Abuse (NCEA). (2020). *Types and signs of abuse*. U.S. Department of Health & Human Services. <https://ncea.acl.gov>
20. Lachs, M. S., & Pillemer, K. A. (2015). Elder abuse. *The New England Journal of Medicine*, 373(20), 1947–1956. <https://doi.org/10.1056/NEJMr1404688>
21. National Center on Elder Abuse (NCEA). (2020). *Types and signs of abuse*. U.S. Department of Health & Human Services. <https://ncea.acl.gov>
22. Lachs, M. S., & Pillemer, K. A. (2015). Elder abuse. *The New England Journal of Medicine*, 373(20), 1947–1956. <https://doi.org/10.1056/NEJMr1404688>

“doctor shopping” by caregivers may signal underlying abuse or caregiver manipulation.

During assessment, it’s crucial to:

- Interview the elder alone, if possible, to ensure their safety and candor.
- Use validated screening tools, such as the Elder Abuse Suspicion Index (EASI) or Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST).²³
- Document findings thoroughly and objectively, including direct quotes, photos (as per policy), and detailed descriptions of injuries or environmental conditions.

Lastly, consider cultural and cognitive factors that may affect an elder’s willingness or ability to disclose abuse. Older adults with dementia or language barriers may require additional support or modified communication strategies.

23. Yaffe, M. J., Wolfson, C., Lithwick, M., & Weiss, D. (2008). Development and validation of a tool to improve physician identification of elder abuse: The Elder Abuse Suspicion Index (EASI). *Journal of Elder Abuse & Neglect*, 20(3), 276–300. <https://doi.org/10.1080/08946560801973168>

Physical Signs of Elder Abuse



Dehydration
or unusual
weight loss



Missing
daily living
aids



Unexplained
injuries, bruises,
cuts, or sores



Unsanitary living
conditions and
poor hygiene



Unattended
medical
needs

To learn more, visit ncea.acl.gov

Figure 15.5 Physical Signs of Elder Abuse. Used under Fair Use.

Interventions

Effective interventions for elder abuse require a coordinated, multidisciplinary response that prioritizes the safety, dignity, and autonomy of the older adult. Once abuse is suspected or confirmed, a key resource is **Adult Protective Services (APS)**. APS agencies are state-run programs that investigate reports of elder and vulnerable adult abuse, neglect, and exploitation. Their role is to protect adults—particularly those with developmental disabilities, degenerative brain disorders, serious mental illness, or other incapacities—who are unable to protect themselves from harm.

APS interventions are tailored to the individual's needs and may include outreach, crisis counseling, and coordination of medical, legal, and social services. Caseworkers assess the level of risk and collaborate with healthcare providers, legal authorities, and family members to ensure safety while respecting the adult's right to self-determination when possible. Services may also include helping arrange safe housing, facilitating access to mental health or substance use treatment, and supporting guardianship proceedings if the individual is deemed unable to make informed decisions.

In cases of financial exploitation, APS may work in tandem with law

enforcement and financial institutions to recover assets or pursue prosecution. When abuse involves a caregiver, interventions can also focus on caregiver support, respite care, and education to reduce stress and prevent recurrence. For institutional settings, reporting to long-term care ombudsman programs and state licensing boards may trigger regulatory reviews and corrective actions.²⁴

See Figure 15.6²⁵ for an illustration related to reporting concerns about vulnerable adults.

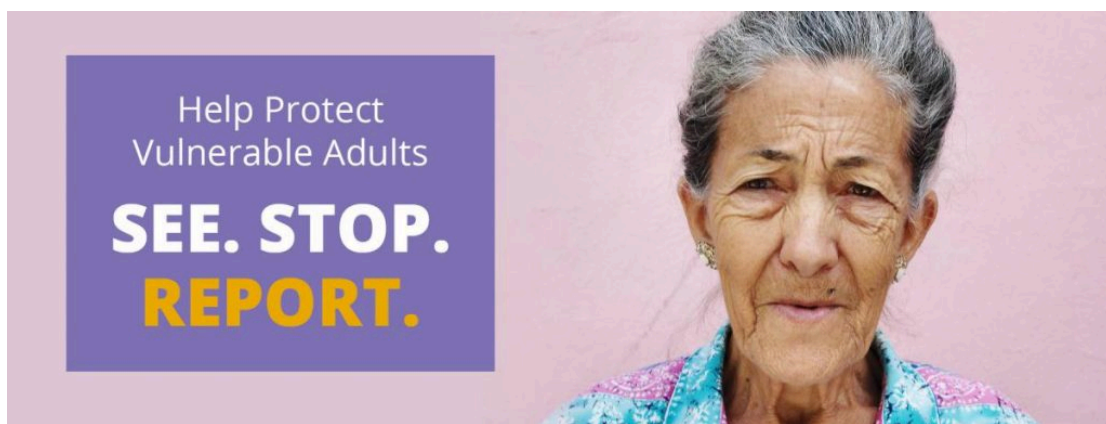


Figure 15.6 Reporting Concerns About Vulnerable Adults. Used under Fair Use.

- Find resources in your area for reporting elder abuse at the [National Adult Protective Services Association website](https://www.napsa-now.org/get-informed/what-is-adult-protective-services/).

24. National Adult Protective Services Association. (n.d.). *Adult Protective Services (APS)*. <https://www.napsa-now.org/get-informed/what-is-adult-protective-services/>

25. “APS_header_3.jpg” by unknown author for [Washington State Department of Social and Health Services](#) is used under Fair Use.

- ▶ Read more about protective services in your state. Here are links to Wisconsin's [Adult Protective Services](#).
- ▶ Find elder care resources in your community at [Eldercare Locator](#)

Mandatory Reporting

Mandated reporters are required by law to report suspected abuse and neglect they see in the course of their professional duties. Nurses and other professionals are referred to as mandated reporters because they are required by state law to report suspected neglect or abuse of children, adults at risk, and the elderly. Nurses should be aware of the county or state agencies to whom they should report suspected abuse. For example, in Wisconsin, suspected neglect or abuse is reported to the Child Protective Services (CPS) or law enforcement. Persons required to report and who intentionally fail to report suspected child abuse or neglect may be fined up to \$1,000 or imprisoned for up to six months or both.²⁶ See Figure 15.7²⁷ for an image related to reporting suspected abuse and neglect.

26. Wisconsin Department of Children and Families. (2019). *It shouldn't hurt to be a child... but sometimes it does*. [PDF Brochure]. <https://dcf.wisconsin.gov/files/publications/pdf/0101.pdf>

27. "[stop-child-abuse-see-the-signs-make-the-call-1536x748.jpg](#)" by unknown author for [Delaware Department of Services for Children, Youth & Their Families](#) is used under Fair Use.



Figure 15.7 Report Suspected Child Abuse. Used under Fair Use.

What to Report

Mandatory reporters who suspect neglect or abuse should contact their county social/human services department, sheriff, or local police department immediately. When making a report, explain what happened or is happening to the child, vulnerable adult, or elderly. Describe the nature of the abuse or neglect and be as specific as possible. Be prepared to give the name, DOB, address, and telephone number of the victim, as well as the name of their parent or caregiver. If you do not know all of this information, report what you do know and explain all you know about the situation and family dynamics.²⁸

When a report is filed, the receiving department will make a safety screening determination based on state statutes. If the report meets the criteria for alleged maltreatment, a social worker from the county department of social/human services will proceed with an investigation of the reported maltreatment and work with the parents or caregiver to assess the situation

28. Wisconsin Department of Children and Families. (2019). *It shouldn't hurt to be a child... but sometimes it does*. [PDF Brochure]. <https://dcf.wisconsin.gov/files/publications/pdf/0101.pdf>

to determine if any support or assistance is needed to protect the child, vulnerable adult, or elderly.²⁹

- ▶ Find resources in your area for reporting suspected child abuse at [ChildHelp National Child Abuse Hotline](#).
- ▶ Read more about protective services in your state. Access Wisconsin's information at [Child Protective Services](#).

29. Wisconsin Department of Children and Families. (2019). *It shouldn't hurt to be a child... but sometimes it does*. [PDF Brochure]. <https://dcf.wisconsin.gov/files/publications/pdf/0101.pdf>

15.5 Intimate Partner Violence

Intimate partner violence (IPV), sexual assault, and rape are crimes with long-lasting effects on victims and are a great cost to society. These crimes happen to both women and men and are often associated with substance use. A recent national survey found that 22 percent of women and 14 percent of men reported experiencing severe physical violence from an intimate partner in their lifetimes.¹ IPV is a significant public health issue that has many individual and societal costs. About 35% of female IPV survivors and more than 11% of male IPV survivors experience some form of physical injury related to IPV, and some deaths occur. About 1 in 5 homicide victims are killed by an intimate partner, and over half of female homicide victims in the US are killed by a current or former male intimate partner.² See Figure 15.8³ for a CDC infographic related to IPV.

1. U.S. Department of Health and Human Services (HHS), Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. [PDF Report].
<https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf>
2. U.S. Department of Health and Human Services (HHS), Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. [PDF Report].
<https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf>
3. "how-big-is-the-problem-ipv-large" by [Centers for Disease Control and Prevention](#) is in the [Public Domain](#). Access for free at <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html>



Figure 15.8 Intimate Partner Violence Statistics

Intimate partner violence (IPV) is abuse or aggression that occurs in a romantic relationship. “Intimate partner” refers to both current and former spouses and dating partners. IPV can vary in how often it happens and how severe it is. It can range from one episode of violence that could have lasting impact to chronic and severe episodes over multiple years. IPV can include any of the following types of behaviors⁴:

- **Physical violence:** When a person hurts or tries to hurt a partner by hitting, kicking, or using another type of physical force
- **Sexual violence:** Forcing or attempting to force a partner to take part in a sex act, sexual touching, or a nonphysical sexual event (e.g., sexting) when the partner does not or cannot consent
- **Stalking:** A pattern of repeated, unwanted attention and contact by a partner that causes fear or concern for one’s own safety or the safety of someone close to the victim
- **Psychological aggression:** The use of verbal and/or nonverbal communication with the intent to harm another partner mentally or emotionally and/or to exert control over another partner

4. Centers for Disease Control and Prevention. (2024). *About violence prevention*. <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html>



View the following CDC YouTube video on intimate partner violence⁵: [What is Intimate Partner Violence?](https://youtu.be/VuMCzU54334)

Teen Dating Violence

When IPV occurs during adolescence, it is referred to as **teen dating violence (TDV)**. TDV affects millions of U.S. teens each year. The use of alcohol and drugs is a risk factor for non-consensual sexual contact among undergraduate and graduate students.⁶ See Figure 15.9⁷ for an infographic used to teach about healthy relationships.

5. Centers for Disease Control and Prevention. (2019, May 15). *What is intimate partner violence?* [Video]. YouTube. All rights reserved.

<https://youtu.be/VuMCzU54334>

6. U.S. Department of Health and Human Services (HHS), Office of the Surgeon General. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. [PDF Report].

<https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf>

7. “teen-dating-violence-relationship-range-chart-graphic.png” by unknown author for [FairFax County Department of Family Services, Domestic and Violent Services](https://www.fairfaxcounty.gov/familyservices/domestic-sexual-violence/teen-dating-violence) is used under Fair Use. Access for free at <https://www.fairfaxcounty.gov/familyservices/domestic-sexual-violence/teen-dating-violence>

HEALTHY	UNHEALTHY	ABUSIVE
A healthy relationship means you and your partner: ▪ Are economic/financial partners ▪ Are equal, honest, respectful and trusting ▪ Communicate ▪ Enjoy spending personal time away from one another ▪ Make mutual choices together <i>Adapted from: Love Is Respect</i>	Your relationship may be unhealthy if your partner: ▪ Is dishonest, disrespectful, or distrustful ▪ Doesn't communicate ▪ Makes you pay for being economically unequal ▪ Only wants you to spend time with each other ▪ Pressures you into activities	Your relationship may be abusive when your partner: ▪ Accuses you of cheating when you're not ▪ Communicates in a threatening or hurtful way ▪ Controls you ▪ Denies their abusive actions ▪ Isolates you from family and friends

Figure 15.9 Healthy Versus Unhealthy and Abusive Relationships. Used under Fair Use.

Warning Signs of Intimate Partner Violence

These observations should heighten a nurse's suspicion of IPV⁸:

- Inconsistent explanation of injuries.
- Delay in seeking treatment for injuries.
- Frequent emergency department or urgent care visits.
(Abusers typically do not want their victims to form an ongoing care relationship with one clinician. They may feel the victim will be less likely to find an ally in an emergency department where care may be more fragmented.)
- Missed appointments. The client may not keep

8. Weil, A. (2024). Intimate partner violence: Diagnosis and screening. *UpToDate*. www.uptodate.com

appointments because the abuser will not allow medical attention.

- Late initiation of prenatal care during pregnancy.
- Repeated abortions. Unplanned pregnancy may result from sexual assault and/or not being allowed to use birth control by the abuser.
- Medication nonadherence. Victims may not take medicines because the abuser has taken them away or not allowed the partner to fill prescriptions.
- Inappropriate affect. Victims may appear jumpy, fearful, or cry readily. They may avoid eye contact and seem evasive or hostile. Additionally, flat affect or dissociation may suggest post-traumatic stress disorder.
- Overly attentive or verbally abusive partner. The clinician should be suspicious if the partner answers questions for the client. If the partner refuses to leave the examination room, the nurse should find a way to get the partner to leave before questioning the client.
- Apparent social isolation.
- Reluctance to undress or have a genital, rectal, or oral examination or difficulty undergoing these or other examinations.

Assessment

The setting in which questioning occurs is important. The nurse must ensure that the client feels safe and comfortable. Individuals are more likely to

disclose their experiences of IPV when the nurse uses the following strategies⁹:

- Provide privacy. Other people present in the room should be asked to leave for the interview and examination. Resistance of a partner to leave is a warning sign.
- Assure confidentiality (unless mandatory reporting is required)
- Use open-ended questioning and ask only a few questions.
- Ask about “being hurt” or “treated badly” and avoid phrases like “victim,” “abused,” or “battered.” Mirror the client’s word choices and use words like “hurt,” “frightened,” or “treated badly.”
- Do not disclose or discuss your concerns with the client’s partner.
- Do not ask why the client has not left their partner.

The physical examination can provide warning signs that abuse may be occurring. The presence and location of injuries are important. Any injury without a good explanation, particularly involving the head and neck, teeth, or genital area, should raise suspicion. Wounds on the forearms often occur when a victim is in a defensive position. Bruises of different ages may be present due to repeated abuse.

People experiencing abuse may deny the abuse for several reasons. They may not feel safe in disclosing information, especially if questions are not asked in a private environment or there is a fear of information not being kept confidential. They may not be emotionally ready to admit the reality of the situation, they may blame themselves, or they may feel like a failure if they admit to being abused. They may fear rejection, feel ashamed, believe that the abuse will not happen again, fear reprisal by the abuser, believe that they have no alternatives, or lack knowledge of resources that could help them. There may be language or cultural barriers between nurses and clients that

9. Weil, A. (2024). Intimate partner violence: Diagnosis and screening. *UpToDate*. www.uptodate.com

interfere with communication or discomfort with using an interpreter to discuss sensitive issues.¹⁰

Routine screening is recommended for all clients on initial primary care visits, OB-GYN visits, emergency department visits, and on hospital admission.¹¹

SAFE Survey

The Joint Commission recommends that hospitals use criteria to identify possible victims of abuse and neglect upon hospital entry and on an ongoing basis, educate staff about how to recognize signs of abuse, assist with referrals of possible victims, and report abuse in accordance with law and regulation.

Several IPV screening tools have been studied for use in emergency departments and clinics. SAFE is an example of a short survey tool that stands for the following assessments^{12,13}:

- **S: Stress/Safety:** Do you feel safe in your relationship?
- **A: Afraid/Abused:** Have you ever been in a relationship where you were threatened, hurt, or afraid?

10. Weil, A. (2024). Intimate partner violence: Diagnosis and screening. *UpToDate*. www.uptodate.com

11. Weil, A. (2024). Intimate partner violence: Diagnosis and screening. *UpToDate*. www.uptodate.com

12. Weil, A. (2024). Intimate partner violence: Diagnosis and screening. *UpToDate*. www.uptodate.com

13. Rabin, R. F., Jennings, J. M., Campbell, J. C., & Bair-Merritt, M. H. (2009). Intimate partner violence screening tools. *American Journal of Preventive Medicine*, 36(5), 439-445.e4. <https://doi.org/10.1016/j.amepre.2009.01.024>

- **F: Friends/Family:** Are your friends or family aware you have been hurt?
- **E: Emergency Plan:** Do you have a safe place to go and the resources you need in an emergency?

► Read the following PDF for additional information about Minnesota Department of Health's IPV screening tools: [Family Home Visiting Intimate Partner Violence Screening & Referrals Toolkit](#)

Interventions and Safety Plans

Survivors of IPV are often afraid to leave their abusive partners because of the threats that have been made against them or their loved ones. The biggest threats for victims are strangulation (ten times more likely to be killed), the presence of a firearm (five times more likely), or if the abusive person is suicidal. It is not uncommon for an abusive person to threaten to kill themselves if they feel as if they're losing control over their partner, and they pose a serious risk to their victim if they have attempted suicide in the past, talk about a specific plan, or have access to a gun. Domestic violence is the single biggest indicator of murder-suicides in the United States, and this has escalated to include survivors' friends and family.¹⁴

Safety is a top priority when IPV is identified. Before the client leaves the office, referrals to local resources should be made with a personalized safety plan in place. The most dangerous time in a relationship occurs when the abused person decides to leave. Nearly 77 percent of domestic violence-related homicides occur upon separation, and there is a 75 percent increase

14. National Domestic Violence Hotline. (n.d.). *Plan for safety*.
<https://www.thehotline.org/plan-for-safety/>

of violence upon separation for at least two years.¹⁵ As the abuser realizes they are losing power and control over their partner, they often escalate tactics to increase fear in the individual leaving the relationship in an effort to make the individual stay. A **safety plan** is a set of actions that can help lower the risk of being hurt by an abusive partner. It includes specific information and resources that will increase one's safety at school, home, and other places visited regularly. View an infographic related to a safety plan in Figure 15.10.¹⁶

15. Battered Women's Support Services. (2020). *Eighteen months after leaving domestic violence is still the most dangerous time*. <https://www.bwss.org/eighteen-months-after-leaving-domestic-violence-is-still-the-most-dangerous-time/>
16. "vaw-covid-1.jpg" by unknown author for [World Health Organization](#) is licensed under [CC BY-NC-SA 3.0 IGO](#). Access for free at <https://www.who.int/multi-media/details/make-a-safety-plan-for-you-and-your-children>

Make a **safety plan** for you and your children:

If you are experiencing violence at home and need to leave in a hurry

Identify a friend, neighbour, relative, or shelter you can go to



Plan how to get there



Keep ready essential personal items to take with you



World Health Organization

human reproduction programme
hrp.
research for impact
UNDP-UNFPA-UNICEF-WHO-WORLD BANK

Figure 15.10 Safety Plan

Resources for Survivors of IPV

- ▶ Guide clients experiencing IPV to create a personalized online safety plan at the National Domestic Violence Hotline's [Create a Safety Plan](#) web page.
- ▶ If you need help or know someone who is experiencing IPV, visit the [National Domestic Violence Hotline](#) or call 1-800-799-7233. Online resources for developing a customized safety plan are available.
- ▶ Read about teen dating and healthy relationships at the [Love is Respect website](#).

Preventing IPV

There are many negative health outcomes associated with IPV, including chronic conditions affecting the heart, digestive, reproductive, musculoskeletal, and nervous systems. Survivors may experience mental health problems such as depression and post-traumatic stress disorder (PTSD) and are at higher risk for engaging in behaviors such as smoking, binge drinking, and risky sexual behaviors.¹⁷

Nurses and communities can promote healthy, respectful, and non-violent relationships to help reduce the occurrence of IPV.¹⁸ See Figure 15.11¹⁹ for an infographic related to IPV prevention strategies from the CDC.

17. Centers for Disease Control and Prevention. (2024). *About violence prevention*. <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html>
18. Centers for Disease Control and Prevention. (2024, April 9). *About violence prevention*. <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html>
19. “how-can-we-stop-ipv.PNG” by [National Center for Injury Prevention and Control, Division of Violence Prevention](#) is in the [Public Domain](#). Access for free at <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html>



Figure 15.11 Preventing Intimate Partner Violence

15.6 Workplace Violence

Workplace violence consists of physically and psychologically damaging actions that occur in the workplace or while on duty. Examples of workplace violence include direct physical assaults (with or without weapons), written or verbal threats, physical or verbal harassment, and homicide.¹

Violence committed by clients or family members toward health care staff can occur in many health care settings. Therefore, nurses must be prepared to cope effectively with agitated clients to reduce the risk of serious injury to the client, themselves, staff, and other clients. Up to 50 percent of health care professionals are victims of violence at some point during their careers. There is a wide range of risk factors for client violence, including the environment, a client's social and medical history, interpersonal relationships, genetics, neurochemistry and endocrine function, and substance abuse. In the emergency department (ED), substance intoxication or withdrawal is the most common diagnosis in combative clients. Known psychiatric illness is also a risk factor for violent behavior, with schizophrenia, personality disorders, mania, and psychotic depression most often associated with violence. Psychosis, delirium, and dementia can also lead to violent behavior.²

Some states are introducing legislation to increase the penalties for people who commit violence against nurses, making battery to a nurse a felony instead of a misdemeanor. A recent law passed in Wisconsin in 2022 makes it

1. Moore, G. P., & Pfaff, J. A. (2022). Assessment and emergency management of the acutely agitated or violent adult. *UpToDate*. www.uptodate.com
2. Moore, G. P., & Pfaff, J. A. (2022). Assessment and emergency management of the acutely agitated or violent adult. *UpToDate*. www.uptodate.com

a felony to threaten a health care worker.³ See Figure 51.12⁴ for an illustration related to stopping workplace violence for nurses in Wisconsin.



Figure 15.12 Stop Workplace Violence. Used under Fair Use.

Assessment of the combative client begins with risk assessment and attention to safety measures. Violence typically erupts after a period of mounting tension. In a typical scenario, the client first becomes angry, then resists authority, and finally becomes confrontational. However, violent behavior may erupt without warning, especially when caused by medical illness or dementia. A nurse may identify verbal and nonverbal cues of agitation and defuse the situation before violence happens. It is helpful to

3. Mensik, H. (2022). *Wisconsin passes law making threats against healthcare workers a felony*. HealthCareDive. <https://www.healthcaredive.com/news/wisconsin-passes-law-threat-healthcare-workers-felony/620978/#:~:text=Wisconsin%20Governor%20Tony%20Evers%20signed,officers%20and%20other%20government%20workers>
4. This image is a derivative of “WP-Violence-graphic-600×800.png” by [Wisconsin Nurses Association](https://www.wisconsinnurses.org/education/workplace-violence/) is used under Fair Use. Access for free at <https://www.wisconsinnurses.org/education/workplace-violence/>

observe the nonverbal communication of a client's hands as an indicator of tension. Other signs of impending violence include the following⁵:

- Confrontational behavior
- Angry demeanor
- Loud, aggressive speech
- Tense posturing (e.g., gripping arm rails tightly or clenching fists)
- Frequently changing body position or pacing
- Aggressive acts (e.g., pounding walls, throwing objects, or hitting oneself)

Clients who are agitated but cooperative may be amenable to verbal de-escalation techniques. Actively violent clients and uncooperative, agitated clients, particularly those who exhibit signs of impending violence, require immediate physical restraint per an agency's policy. Assume that all violent clients are armed until proven otherwise, especially those presenting to an emergency department.⁶

► Read about crisis intervention techniques in the "[Stress, Coping, and Crisis Intervention](#)" chapter.

Verbal De-Escalation Techniques

Verbal de-escalation techniques should be attempted before physical restraints or sedative medications are implemented. During initial interactions with the client, it will rapidly become clear whether the client will

5. Moore, G. P., & Pfaff, J. A. (2022). Assessment and emergency management of the acutely agitated or violent adult. *UpToDate*. www.uptodate.com
6. Moore, G. P., & Pfaff, J. A. (2022). Assessment and emergency management of the acutely agitated or violent adult. *UpToDate*. www.uptodate.com

cooperate or continue to escalate. This interaction also enables the nurse to assess the client's mental status. If the client remains agitated or is incapable of interacting appropriately, then restraints become necessary.⁷

When attempting to de-escalate an individual, the nurse should adopt an honest and straightforward manner. Friendly gestures can be helpful. Offer a comfortable place to sit or something to eat or drink (but not a hot liquid that could be used as a weapon) to establish trust. Many individuals will decompress at this point because offering food or drink appeals to their most basic human needs and builds trust.⁸

The nurse should demonstrate a nonconfrontational, attentive, and receptive demeanor without conveying weakness or vulnerability. A calm and soothing tone of voice should be used. Avoid direct eye contact, do not approach the client from behind or move suddenly, and stand at least two arm's lengths away.⁹ The nurse should ensure a quick exit route to the door and never allow the individual to come between them and the door. Stethoscope and badge holders should not be worn around the neck to prevent strangulation risks.

In some cases, an agitated client may be aware of their impulse control problem and may welcome limit-setting behavior by the nurse (e.g., "I can help you with your problem, but I cannot allow you to continue threatening me or the emergency department staff"). It is difficult to predict which clients

7. Moore, G. P., & Pfaff, J. A. (2022). Assessment and emergency management of the acutely agitated or violent adult. *UpToDate*. www.uptodate.com
8. Moore, G. P., & Pfaff, J. A. (2022). Assessment and emergency management of the acutely agitated or violent adult. *UpToDate*. www.uptodate.com
9. Moore, G. P., & Pfaff, J. A. (2022). Assessment and emergency management of the acutely agitated or violent adult. *UpToDate*. www.uptodate.com

will respond to this limit-setting approach. Some clients may interpret such statements as confrontational and escalate their behavior.¹⁰

A key mistake when interviewing an agitated or potentially violent individual is failing to address violence directly. They should be asked relevant questions, such as, “Do you feel like hurting yourself or someone else?” and “Do you carry a gun?” Stating the obvious (e.g., “You look angry”) may help them to begin sharing their emotions. Speak in a conciliatory manner and offer supportive statements to diffuse the situation, such as, “You obviously have a lot of will power and are good at controlling your emotions.”¹¹

A consensus statement from the American Association for Emergency Psychiatry De-escalation Workgroup describes these ten key elements for verbal de-escalation¹²:

- **Respect personal space:** Maintain a distance of two arm’s lengths and provide space for easy exit for either party.
- **Do not be provocative:** Keep your hands relaxed, maintain an open body posture, and do not stare at the client.
- **Establish verbal contact:** The first person to contact the client should take the lead in communicating.
- **Use concise, simple language:** Avoid elaborate and technical terms because they are hard for an impaired person to understand.
- **Identify feelings and desires:** “What are you hoping for?”
- **Listen closely to what the client is saying:** After listening, restate what

10. Moore, G. P., & Pfaff, J. A. (2022). Assessment and emergency management of the acutely agitated or violent adult. *UpToDate*. www.uptodate.com

11. Moore, G. P., & Pfaff, J. A. (2022). Assessment and emergency management of the acutely agitated or violent adult. *UpToDate*. www.uptodate.com

12. Moore, G. P., & Pfaff, J. A. (2022). Assessment and emergency management of the acutely agitated or violent adult. *UpToDate*. www.uptodate.com

the client said to improve mutual understanding (e.g., “Tell me if I have this right...”).

- **Agree or agree to disagree:** Agree with clear specific truths or agree in general (e.g., “Yes, everyone should be treated respectfully.”)
- **Set clear limits:** Inform the client that violence or abuse cannot be tolerated.
- **Offer choices and optimism:** Clients feel empowered if they have some choice in matters.
- **Debrief the client and staff.**

The “philosophy of yes” is a de-escalation technique that encourages the nurse to respond affirmatively to an agitated individual. Examples of initial responses using this approach include “Yes, as soon as,” “Okay, but first we need to,” or “I absolutely understand why you want that done, but in my experience, there are better ways of getting what you need.”¹³

However, some approaches to the combative client are counterproductive and can lead to escalation. Arguing, condescension, or commanding the client to calm down can have disastrous consequences. Clients often interpret such approaches as a challenge to “prove themselves.” A threat to call security personnel can also invite aggression. Other potential mistakes include criticizing or interrupting the client, responding defensively or taking the client’s comments personally, or not clarifying what the client wants before responding.¹⁴

Never lie to a client (e.g., stating “I am sure you will be out of here in no time” when this is not the case). After the lie becomes apparent, the client may take out frustrations violently upon an unsuspecting nurse or colleague. Take all

13. Moore, G. P., & Pfaff, J. A. (2022). Assessment and emergency management of the acutely agitated or violent adult. *UpToDate*. www.uptodate.com

14. Moore, G. P., & Pfaff, J. A. (2022). Assessment and emergency management of the acutely agitated or violent adult. *UpToDate*. www.uptodate.com

threats seriously. It is especially important not to deny or downplay threatening behavior. If verbal techniques are unsuccessful and escalation occurs, the nurse should excuse themselves and summon help.¹⁵

Many hospitals have multidisciplinary Behavioral Emergency Response Teams (BERTs) that respond to behavioral emergencies. Their overall goal is to provide timely and effective intervention for patients exhibiting disruptive or potentially dangerous behaviors, reducing the risk of harm to both patients and staff.¹⁶

Applying Physical Restraints

Physical restraints may be used when verbal de-escalation techniques are unsuccessful despite a professional approach to the combative client. Restraints should never be applied for convenience or punishment, and they should be removed as soon as possible, usually after adequate chemical sedation is achieved or the client has regained control.

Restraints should be implemented systematically using an institutional protocol. The protocol typically begins after the examiner leaves the room when verbal de-escalation techniques have been unsuccessful, and assistance is summoned. It can be helpful to consider the application of restraints like a procedure, similar to running an advanced cardiac life support code.¹⁷

15. Moore, G. P., & Pfaff, J. A. (2022). Assessment and emergency management of the acutely agitated or violent adult. *UpToDate*. www.uptodate.com
16. Parker, C. M., Calhoun, A., Wong, A. et al. (2020). A call for behavioral emergency response teams in inpatient hospital settings. *AMA Journal of Ethics*, 22(11), E956-964. [doi: 10.1001/amajethics.2020.956](https://doi.org/10.1001/amajethics.2020.956).
17. Moore, G. P., & Pfaff, J. A. (2022). Assessment and emergency management of the acutely agitated or violent adult. *UpToDate*. www.uptodate.com

The restraint team should have at least five people, including a team leader. The leader is the only person giving orders and should be the person with the most experience implementing restraints, whether a clinician, nurse, or security officer. Before entering the room, the leader outlines the restraint protocol and warns the team of anticipated dangers (e.g., the presence of objects that may be used as weapons). All team members should remove personal effects (e.g., stethoscopes, pens, jewelry, etc.) the combative client could use against them. If the client to be restrained is female, at least one member of the restraint team should be female to diminish potential allegations of sexual assault.¹⁸

The restraint team should enter the room in force and display a professional, rather than threatening, attitude. Many violent individuals decompress at this point because the show of force protects their ego (e.g., “I would have fought back, but there were too many against me”). The leader speaks to the client in a calm and organized manner, explaining why restraints are needed and what the course of events will be (e.g., “You will receive a medical and psychiatric examination, as well as treatment”). The client is instructed to cooperate and lie down to have restraints applied. Some clients will be relieved at the protection to self and others afforded by restraints when they feel themselves losing control. However, even if the client suddenly appears less dangerous, physical restraints must be placed after the decision to use them has been made; do not negotiate with the client at this point.¹⁹

If it becomes necessary to use force to control the client, one team member restrains a preassigned extremity by controlling the major joint (e.g., knee or elbow). This can be accomplished by locking the major joint in extension. The team leader controls the head. If the client is armed with a makeshift weapon,

18. Moore, G. P., & Pfaff, J. A. (2022). Assessment and emergency management of the acutely agitated or violent adult. *UpToDate*. www.uptodate.com

19. Moore, G. P., & Pfaff, J. A. (2022). Assessment and emergency management of the acutely agitated or violent adult. *UpToDate*. www.uptodate.com

two mattresses can be used to charge and immobilize or sandwich the client. Restraints are applied securely to each extremity and tied to the solid frame of the bed (not side rails because later repositioning of side rails also repositions the client's extremity). To prevent their lower extremities from flailing independently, it may be best to cross the legs at the ankle and then attach the restraint to the bed frame on the opposite side.²⁰

Leather is the optimal material for restraining a combative client because it is strong, prevents escape, and is less constricting than typical soft restraints. Gauze should not be used. Soft restraints are helpful in restricting extremity use in a semi-cooperative client but are less effective in a truly violent client who continues to struggle. If chest restraints are used, it is vital to ensure adequate chest expansion for ventilation. Never apply pressure to the client's chest or back while they are immobilized due to asphyxiation risk. After the client is immobilized, announcing "The crisis is over" can have a calming effect on the restraint team and the client.²¹

After restraints have been applied, the client should be monitored frequently and their position changed regularly to prevent circulatory obstruction, pressure injuries, and paresthesias, as well as to avoid rhabdomyolysis associated with continued combativeness. A standardized form based on agency policy is typically used for documentation. Documentation should include the specific indication for restraints and alternatives attempted. In addition to monitoring, nurses must ensure that basic needs (e.g., hydration, food, toileting) are met for any client who is physically restrained or

20. Moore, G. P., & Pfaff, J. A. (2022). Assessment and emergency management of the acutely agitated or violent adult. *UpToDate*. www.uptodate.com

21. Moore, G. P., & Pfaff, J. A. (2022). Assessment and emergency management of the acutely agitated or violent adult. *UpToDate*. www.uptodate.com

chemically sedated. Physical restraints should be removed as soon as possible.²²

- ▶ Review ANA guidelines for using restraints in the “[Client Rights](#)” section of the “Legal and Ethical Considerations in Mental Health Care” chapter.

- ▶ View a supplementary YouTube video²³ on how to apply soft wrist restraints: [Restraint Application Techniques for Nurses](#)

Chemical Sedation

Chemical sedation may be necessary, with or without physical restraints, in a combative client who does not respond to verbal de-escalation techniques. The ideal sedative medication for an agitated or violent client is rapid-acting with minimal side effects. The major classes of medications used to control the violent or agitated client include benzodiazepines, first-generation

22. Moore, G. P., & Pfaff, J. A. (2022). Assessment and emergency management of the acutely agitated or violent adult. *UpToDate*. www.uptodate.com

23. NURSINGcom w/ Jon Haws, RN. (2021, October 13). *Restraint application techniques for nurses* [Video]. YouTube. All rights reserved. <https://www.youtube.com/watch?v=S3uPFcU4qRo>

(typical) antipsychotics, second-generation (atypical) antipsychotics, and ketamine²⁴:

- For severely violent clients requiring immediate sedation, a rapid-acting first-generation antipsychotic (e.g., haloperidol or droperidol), benzodiazepine (e.g., midazolam), or a combination of both may be prescribed. Second-generation antipsychotics, such as olanzapine, risperidone, and ziprasidone may also be prescribed.
- For clients with agitation from drug intoxication or withdrawal from an unknown cause, benzodiazepines are typically prescribed. Lorazepam and midazolam are used most often. Benzodiazepines may cause respiratory depression and excessive sedation, so close monitoring is essential after administration.
- Ketamine may be prescribed when initial treatments with benzodiazepines or antipsychotics have failed, especially in clients with excited delirium. However, clients receiving ketamine have increased risk for respiratory distress and may require endotracheal intubation and mechanical ventilation.

Post-Restraint Evaluation

After the client is restrained, the cause of their agitation will be evaluated to determine if it is medical, psychiatric, or substance-use related. Clients over the age of 40 with new psychiatric symptoms are likely to have a medical cause. Elderly clients are at higher risk for delirium due to medical illness (such as a urinary tract infection) or adverse reactions to medications. Clients with a history of drug or alcohol use disorder may exhibit violent behavior as a manifestation of an intoxication or withdrawal syndrome. Violent behavior

24. Moore, G. P., & Pfaff, J. A. (2022). Assessment and emergency management of the acutely agitated or violent adult. *UpToDate*. www.uptodate.com

unrelated to medical illness, drug intoxication, or withdrawal should be followed by psychiatric consultation and evaluation.²⁵

Defense Against Assault

Physical assault may occur despite appropriate precautions and interventions with a violent individual. If assaulted, immediately summon help. Maintain a sideward posture, keeping the arms ready for self-protection. If faced with an oncoming punch or a kick, deflect with an arm or a leg. If choking is attempted, tuck in the chin to protect the airway and carotid arteries. If bitten, do not pull away, but rather push toward the mouth and hold the nares shut to entice the opening of the mouth.²⁶ In a similar manner, don't pull away if your hair is pulled, but instead pull the client's hand toward your head and push up to bend their wrist backwards and increase the likelihood of them releasing their grip due to pain.

If threatened with a weapon, try to appear calm and comply with the individual's demands. Adopt a nonthreatening posture and avoid sudden movements. Do not attempt to reach for the weapon. Avoid arguing, despair, or whining. If taken hostage, attempt to establish a human connection with the hostage taker because there is less risk of violence if a relationship has been established. Do not bargain, make promises, or lie because the consequences could be disastrous. Reassure the hostage taker that an authorized person should arrive promptly to hear their complaints or demands. If a weapon is put down, do not reach for it, but rather attempt to verbally resolve the crisis while awaiting arrival of law enforcement.²⁷

- 25. Moore, G. P., & Pfaff, J. A. (2022). Assessment and emergency management of the acutely agitated or violent adult. *UpToDate*. www.uptodate.com
- 26. Moore, G. P., & Pfaff, J. A. (2022). Assessment and emergency management of the acutely agitated or violent adult. *UpToDate*. www.uptodate.com
- 27. Moore, G. P., & Pfaff, J. A. (2022). Assessment and emergency management of the acutely agitated or violent adult. *UpToDate*. www.uptodate.com

Every hospital should have a written plan of action to implement in the case of extreme violence. The plan should include prevention and safety measures, a means for rapid notification of security and police personnel, evacuation plans, medical treatment, and crisis intervention. A novel approach uses a trained violence management team to provide a mechanism for dealing with aggressive clients and to protect the staff.²⁸

Mandatory training for clinical and non-clinical staff must also be incorporated with written plans of action. This multifaceted approach improves nurses' self-perception and confidence against workplace violence.²⁹

Interpersonal Conflict Among Health Care Team Members

Conflict is inevitable when working on a health care team composed of members with different personalities, roles, and responsibilities. Some conflicts among team members can escalate to verbal threats or harassment. Common sources of interpersonal conflict in health care settings are passive-aggressiveness, horizontal aggression, defensiveness, peer informer behavior, and victimization behaviors. It is essential for all nurses to develop conflict resolution skills to effectively address these behaviors and maintain a safe work environment.

28. Moore, G. P., & Pfaff, J. A. (2022). Assessment and emergency management of the acutely agitated or violent adult. *UpToDate*. www.uptodate.com
29. Ming, J. L., Huang, H. M., Hung, S. P., Chang, C. I., Hsu, Y. S., Tzeng, Y. M., Huang, H. Y., & Hsu, T. (2019). Using simulation training to promote nurses' effective handling of workplace violence: A quasi-experimental study. *International Journal of Environmental Research and Public Health*, 16(19), 3648. <http://dx.doi.org/10.3390/ijerph16193648>

- ▶ Read more information about interpersonal conflict and conflict resolution skills in the “[Conflict Resolution](#)” section of the “Collaboration Within the Interprofessional Team” chapter of Open RN *Nursing Management and Professional Concepts*.

15.7 Applying the Nursing Process to Clients Experiencing Trauma, Abuse, or Violence

This section will provide an overview of applying the nursing process to clients experiencing trauma, abuse, or violence using trauma-informed care principles. Review specific focused assessments and nursing interventions in the preceding sections.

Assessment (Recognizing Cues)

Assessment focuses on recognizing physical, psychological, and behavioral indicators of trauma, abuse, or violence. Key actions include the following:

- Recognize injuries inconsistent with explanations (e.g., bruises, fractures, burns).
- Recognize nonverbal cues (e.g., flinching, hypervigilance, avoidance).
- Ensure assessment occurs in a safe, private space, free from potential abusers.
- Screen for anxiety, depression, PTSD, dissociation, or suicidal ideation.

Diagnosis (Analyzing Cues)

Nurses create nursing diagnoses based on assessment data obtained. Potential nursing diagnoses for clients experiencing trauma, abuse, or violence include the following:

- Risk for Post-Trauma Syndrome
- Ineffective Coping
- Powerlessness
- Impaired Social Interaction
- Sleep Pattern Disturbance
- Chronic Low Self-Esteem

Outcome Identification (Generate Solutions)

SMART outcomes are identified in relation to the established nursing

diagnoses for each client. SMART is an acronym for Specific, Measurable, Attainable/Actionable, Relevant, and Timely. Read more about outcomes identification in the “[Application of the Nursing Process in Mental Health Care](#)” chapter.

Examples of SMART outcomes for clients experiencing trauma, abuse, or violence include the following:

- *The client will verbalize how to contact a safe person or environment if in crisis by the end of the teaching session.*
- *The client will identify at least one positive coping strategy by the end of the teaching session.*

Planning (Generate Solutions)

Safety receives top priority when planning and implementing interventions for clients experiencing trauma, abuse, or violence. Nurses help ensure a safety plan is created in collaboration with the client by integrating information about community resources, legal advocacy, and counseling resources. Nurses also help ensure the client’s physical care needs are addressed (e.g., food, housing, pain control, and wound care).

Implementation (Take Action)

Nurses implement nursing interventions that are therapeutic, respectful, and empowering. Examples of nursing interventions for clients experiencing trauma, abuse, or violence include the following:

- Use grounding techniques to manage dissociation and anxiety.
- Educate client about normal trauma responses and coping tools.
- Offer emotional support and validate their experiences without pressuring for disclosure.
- Facilitate referrals to mental health, social work, domestic violence shelters, or trauma-specific therapy.
- Monitor for suicidal ideation and psychosis.

Evaluation (Evaluate Outcomes)

Nurses assess the effectiveness of nursing interventions and revise the nursing care plan as needed. They evaluate client's verbal and nonverbal indicators of emotional safety, determine if the expected outcomes were met, and support continuation of trauma-specific therapy.

15.8 Spotlight Activity

This Spotlight Activity is based on a real case originally presented in, “Trauma-Informed Care in Nursing Practice” by Dowdell and Speck (2022). Identifying details have been changed or omitted to protect the anonymity of the client.¹

Dana is a 34-year-old female who arrived at the Emergency Department with a neck injury she reports “happened this morning when I slipped and fell.” The nurse notes that Dana’s address given is in a different community about 50 miles away from the hospital. Initial physical examination revealed bruise patterns in various stages of healing all over Dana’s body and three linear abrasions over the trapezius muscle on the right side of the neck consistent with attempted strangulation.

While awaiting diagnostic testing results, the nurse established a therapeutic nurse-client relationship and asked Dana a few follow-up questions about the events leading up to the injury and the relationship with her partner. Dana stated, “We fight a lot” and “My partner has a lot of angry outbursts.” Upon the nurse’s use of effective therapeutic communication, Dana shared that the injury resulted from “being choked and beaten,” and the partner had done similar actions on “several previous occasions in front of the children.” Dana then told the nurse, “My partner can’t find out that I am here in this hospital.”

A contrast computed tomography (CT) scan revealed swelling of Dana’s right carotid artery and soft tissue in the neck. Laboratory tests also indicated that Dana had severely elevated blood sugars resulting in diabetic ketoacidosis (DKA). The health care team initiated a medication regimen to safely manage the DKA and also prevent a stroke from the injury.

The nurse noted that, over time, Dana became increasingly agitated in the ED

1. Dowdell, E., & Speck, P. (2022). Trauma-informed care in nursing practice. *American Journal of Nursing*, 122(4), 30-38. https://journals.lww.com/ajnonline/Fulltext/2022/04000/CE_Trauma_Informed_Care_in_Nursing_Practice.22.aspx

with repetitive neurological assessments, fingersticks for bedside glucose levels, and the noises and high activity level of the ED. Establishing physical and psychological safety for both Dana and staff became a nursing priority during Dana's time in the ED.

Following trauma-informed care (TIC) guidelines to create a safe environment, the nurse asked Dana, "What do you need to feel safe here right now?" Dana immediately responded, "I can't have all these people coming at me. It's too much – too much noise, too many people touching me, it's just too much." The nurse moved Dana out of the trauma bay, which was near the ambulance entryway, and into a room where the nurse was able to close the door. The nurse also posted signage on the door asking all staff and visitors to contact the nurse before entering the room. Following agency protocol, the nurse swiftly gained Dana's consent for anonymity, meaning the client's name and room number(s) would not be shared with anyone outside of the hospital. Following these nursing actions, Dana's anxiety and agitation levels dropped noticeably in the ED. When an ICU bed became available, she was transferred there for medical management.

Dana was present during the handoff report from the ED nurse to the ICU nurse to validate information and it also improved Dana's sense of safety. Following the TIC cue given by the ED nurse, the ICU nurse asked Dana, "What else do you need to feel safe here right now?" Dana requested a private room, if available, to rest, listen to music, and "stay calm." The ICU nurses implemented a safety plan that included consistent staff and coordinated, clustered care. This plan minimized disturbances, thereby providing dedicated periods for rest between timed blood glucose monitoring and nursing monitoring of Dana's neurologic state and neck swelling.

While in the ICU, the nurses taught Dana evidence-based methods for reducing anxiety, including deep breathing, grounding techniques, and moderating anxiety-provoking stimuli such as social media and electronics. In addition, the nurses noted the vocal and nonverbal cues that indicated Dana was feeling anxious, such as speaking in a raised voice or using rapid hand

movements while speaking. Noticing these behaviors allowed nurses to ask follow-up questions such as “Do you feel safe at this moment,” then review anxiety-reducing techniques by asking Dana, “Which technique would you like to use now?” By offering person-centered choices and creating a predictable structure around clustered nursing actions, the nurses promoted a feeling of safety for Dana as well as techniques to self-regulate anxiety.

The health care team identified Dana’s priority health concerns as DKA management and decreasing the risk for a stroke following nonfatal carotid trauma. The nursing team added Dana’s increased risk for subsequent fatal strangulation as a priority concern that must be addressed before discharge. However, when asked by the nurses, “What is important to you to include in your discharge plan,” Dana identified the priorities of finding safe housing and employment with fair pay. Therefore, the nursing team recommended that upon discharge, Dana would transfer directly to community wraparound services for a variety of assistance including transitional housing, job training, day care, medical care, and cognitive behavioral therapy.

Reflective Questions

1. What actions did the nurses perform with Dana to implement Trauma Informed Care (TIC)?
2. What other actions do you plan to implement with your patients regarding TIC?
3. “Dana” could be a male or a female, and Dana’s “partner” could be a male or a female. Do gender differences or sexual orientation affect your attitudes toward Dana’s risks and follow-up care?
4. How might Dana’s children be affected by Dana’s ongoing abuse?
5. What if Dana’s partner showed up at the hospital with a gun threatening to kill Dana? How would you respond as a

nurse to keep yourself, other clients, and staff safe?

15.9 Learning Activities



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<https://wtcs.pressbooks.pub/nursingmhcc/?p=1042#h5p-51>

1



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<https://wtcs.pressbooks.pub/nursingmhcc/?p=1042#h5p-50>

2



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1. “Trauma, Abuse, and Violence Glossary Cards” by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)
2. “Trauma, Abuse, and Violence Unfolding Case Study by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)

online here:

<https://wtcs.pressbooks.pub/nursingmhcc/?p=1042#h5p-52>

3

- ▶ Test your clinical judgment with an NCLEX Next Generation-style question: [Chapter 15, Assignment 1](#)⁴



- ▶ Test your clinical judgment with an NCLEX Next Generation-style case study: [Chapter 15, Case Study 1](#)⁵



3. "Trauma, Abuse, and Violence Drag and Drop" by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)
4. "Trauma, Abuse, and Violence Next Gen Question 1" by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)
5. "Trauma, Abuse, and Violence Next Gen Case Study" by Kellea Ewen is licensed under [CC BY-NC 4.0](#)

XV Glossary

Adults at risk: Adults who have a physical or mental condition that impairs their ability to care for their own needs.

Adult Protective Services (APS): APS agencies are state-run programs that investigate reports of elder and vulnerable adult abuse, neglect, and exploitation.

Adverse childhood experiences (ACE): Traumatic experiences during childhood such as neglect, abuse, or witnessing violence, substance abuse, mental illness, divorce, or imprisonment of a family member.

Caregiver: A person who has taken responsibility for all or part of an individual's care.

Dissociation: A break in how the mind handles information, causing a person's disconnection from their thoughts, feelings, memories, and surroundings.

Elder abuse: An intentional act or failure to act that causes or creates a risk of harm to an older adult aged 60 or older.

Emotional abuse: Verbal or nonverbal behaviors that inflict anguish, mental pain, fear, or distress, such as humiliation or disrespect, verbal and nonverbal threats, harassment, and geographic or interpersonal isolation.

Financial abuse: The illegal, unauthorized, or improper use of money, benefits, belongings, property, or assets for the benefit of someone other than the individual.

Individual trauma: Trauma resulting from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and can have lasting adverse effects on their functioning and mental, physical, social, emotional, or spiritual well-being. Adverse childhood experiences are examples of individual traumas.

Intimate partner violence (IPV): Abuse or aggression that occurs in a

romantic relationship. IPV can include physical violence, sexual violence, stalking, or psychological aggression.

Mandated reporters: Nurses and other professionals required by state law to report suspected neglect or abuse of children, adults at risk, and the elderly they see in the course of their professional duties.

Neglect: When a parent or caregiver fails, refuses, or is unable, for reasons other than poverty, to provide the necessary care, food, clothing, or medical or dental care, which seriously endangers the physical health of a child or vulnerable adult.

Physical abuse: Injury inflicted on a child or vulnerable adult by other than accidental means. Physical injury includes, but is not limited to, lacerations, fractured bones, burns, internal injuries, severe or frequent bruising, or great bodily harm.

Resilience: The ability to rise above circumstances or meet challenges with fortitude. Resilience includes the process of using available resources to negotiate hardship and/or the consequences of adverse events.

Resilient zone: A healthy balance of stimulation by the sympathetic nervous system (SNS) and parasympathetic nervous system (PNS).

Safety plan: A set of actions that can help lower the risk of a person being hurt by an abusive partner that includes specific information and resources that increases their safety at school, home, and other places visited regularly.

Sexual abuse: Sexual intercourse or sexual touching; sexual exploitation; human trafficking; forced viewing of sexual activity; or permitting, allowing, or encouraging prostitution with a child or vulnerable adult.

Teen dating violence: Intimate partner violence that occurs during adolescence.

Trauma-focused cognitive behavioral therapy (TF-CBT): An evidence-based

treatment that helps children process trauma, develop coping skills, and reduce symptoms of anxiety, depression, or post-traumatic stress.

Trauma-informed care (TIC): A strengths-based framework that acknowledges the prevalence and impact of traumatic events in clinical practice, placing an emphasis on instilling in clients a sense of safety, control, and autonomy over their life and health care decisions. The basic goals of TIC are to avoid retraumatization; emphasize survivor strengths and resilience; aid empowerment, healing, and recovery; and promote the development of survivorship skills.

Workplace violence: Physically and psychologically damaging actions that occur in the workplace or while on duty. Examples of workplace violence include direct physical assaults (with or without weapons), written or verbal threats, physical or verbal harassment, and homicide.

PART XVI

CHAPTER 16 COMMUNITY ASSESSMENT

Learning Objectives

- Identify the needs of the populations that impact health-seeking behaviors
- Identify available resources for the health needs of the community
- Explain the nurse role as a collaborative advocate for the health needs of the community
- Apply evidence-based practice when implementing the nursing process in the community
- Differentiate the role of the Registered Nurse in community health care settings

Most of your nursing education journey has likely focused on caring for clients in hospitals and long-term care settings. However, nurses also serve important roles in promoting the health and wellness of communities. Throughout history, nurses have served in public health roles and collaborated with community organizations to support health services. Florence Nightingale, the founder of modern nursing, advocated for two foundational components of community health nursing: health promotion and disease prevention.¹ Examples of current community health initiatives include public educational health sessions, blood pressure screenings,

1. McDonald, L. (2006). *Florence Nightingale and public health policy: Theory, activism and public administration*. University of Guelph.
<https://cwfn.uoguelph.ca/nursing-health-care/fn-and-public-health-policy/>

immunization clinics, and crisis intervention related to mental health care. See Figure 16.1² for an image of a community blood pressure screening.



Figure 16.1 Community Health Screening

In recent years community health nursing has become increasingly important for several reasons:

- There are currently shorter hospital stays and decreasing hospital readmission rates.
- As the average age of the United States population increases, the need for community health services in members' homes increases.
- As the ability to successfully manage chronic conditions (including both physical and mental illness) improves, the need for outpatient health services also increases.
- As the usage of telehealth and virtual medical care expands, so does the need for community member support and client education.

2. "[7315182496_0cd3e18ed6_k](#)" by [Maryland GovPics](#) is licensed under [CC BY 2.0](#)

This chapter will introduce the roles of community health nurses, explore community health needs assessments, and discuss how nurses collaborate with community resources to support clients' physical and mental health care needs.

16.2 Community Health Concepts

Community Health Nursing

Community health nurses work in diverse settings, including public health agencies, schools, and faith-based organizations. Their roles vary but share a common goal: promoting health and addressing the needs of populations within their communities.

Public health nurses work across various settings in the community such as government agencies, community-based centers, shelters, and vaccine distribution sites. They provide disease prevention and health promotion services, such as working with mothers and children to improve nutrition, operating immunization clinics, and leading public health education initiatives such as smoking cessation campaigns. Public health nurses also prepare to respond quickly to public health emergencies such as natural disasters or epidemics.¹² Emergency preparedness is further discussed in the “[Environmental Health and Emergency Preparedness](#)” chapter. See Figure 16.2³ for an image of a community health nurse providing health screenings in a maternal and child health clinic.

1. Greenwood, B. (n.d.). *What are the primary roles of the community nurse?* CHRON. <https://work.chron.com/primary-roles-community-nurse-15144.html>
2. National Academy of Medicine. (2021). *The future of nursing 2020-2030: Charting a path to achieve health equity* [PDF Report]. <https://www.phnurse.org/assets/docs/FON%20Valuing%20Community%20and%20Public%20Health%20Nursing.pdf>
3. “[PIXNIO-45563-3000×2000](#)” by [USAID](#) on [Pixnio](#) is licensed under [CC0](#)



Figure 16.2 Health Screenings

School nurses provide a specialized practice of nursing which protects and promotes student health, facilitates optimal development, and advances academic success. School nurses, grounded in ethical and evidence-based practice, are the leaders who bridge health care and education, provide care coordination, advocate for quality student-centered care, and collaborate to design systems that allow individuals and communities to develop their full potentials. School nurses provide direct healthcare, administer medications and treatments, develop health care plans and emergency action plans, provide health screenings, collaborate with parents and medical providers and promote student health and safety and so much more. For example, school nurses may help develop disaster plans that coordinate activities in the school with the larger neighborhood.^{4,5}

4. Greenwood, B. (n.d). *What are the primary roles of the community nurse?* CHRON. <https://work.chron.com/primary-roles-community-nurse-15144.html>
5. National Academy of Medicine. (2021, May). *The future of nursing 2020-2030:*

Parish nurses also known as faith community nurses, integrate professional nursing with spiritual care to promote holistic health within faith-based communities. Serving in both paid and volunteer roles, they work primarily within churches, addressing the physical, emotional, and spiritual needs of their congregations. Their responsibilities encompass administering vaccinations, assisting with end-of-life care discussions, coordinating among healthcare providers, and leading support groups. Additionally, they visit congregation members in homes or hospitals, offering spiritual support during health challenges. By acting as liaisons between healthcare systems and congregations, parish nurses advocate for quality, client-centered care while honoring individuals' spiritual beliefs.

Beyond church settings, parish nurses contribute to community health by working in hospitals, long-term care facilities, medical clinics, and social service agencies. In hospitals and long-term care environments, they often collaborate with chaplains to provide comprehensive spiritual care. Their unique role emphasizes integrating faith and health, transforming faith communities into sources of healing and support.⁶

Barriers for Community Health Nurses

Community health nurses play a crucial role in identifying the health needs of a community and planning and implementing preventative health initiatives. However, they often face specific challenges when providing care to individuals, families, and community members. Three key barriers are gaining entry, role negotiation, and confidentiality:

Charting a path to achieve health equity [PDF Report].

<https://www.phnurse.org/assets/docs/FON%20Valuing%20Community%20and%20Public%20Health%20Nursing.pdf>

6. Greenwood, B. (n.d.). *What are the primary roles of the community nurse?* CHRON. <https://work.chron.com/primary-roles-community-nurse-15144.html>

- **Gaining Entry:** Community health nurses may be considered “outsiders” as representatives of the established health care system and may not necessarily be trusted by community members. It is vital for community health nurses to build trust and supportive relationships. When working with individuals and families, nurses should assess specific community issues affecting that individual's health or their access to health care and then address those issues in their nursing care plan. Nurses can also investigate if there are community resources available to refer the client and/or their family members for additional services. See Figure 16.3⁷ for an image of Red Cross volunteers working with caregivers of clients receiving palliative care.
- **Role Negotiation and Confidentiality:** Community health nurses must separate their roles as data collectors, health professionals, and neighbors. These roles can be difficult to differentiate when the nurse is assessing community health needs and providing nursing interventions for a population of individuals within their own home community. These individuals may include family members, friends, neighbors, or peers. Trust must be established and confidentiality assured according to legal and ethical parameters of nursing practice. Nurses should also establish a sense of partnership and encourage clients to participate in planning preventative health strategies for themselves and their families.

7. “10716898813_74292ef548_k” by [Department of Foreign Affairs and Trade](#) is licensed under [CC BY 2.0](#)



Figure 16.3 Setting Up Support Groups for Caregivers

Other barriers that community health nurses may experience include limited resources and funding, workforce shortages, staff burnout, and feelings of isolation from the healthcare community.⁸

Community Health

Community health nursing is grounded in key principles: promoting healthy living, preventing illness, facilitating rehabilitation, evaluating community resources, and advocating for overall health improvement.^{9,10} In this manner,

8. Seyedfatemi, N., Peyrovi, H., Goharinezhad, S., & Oghli, S. H. (2024). Barriers and facilitators of community-based nursing development: A scoping review. *Journal of Education and Health Promotion*, 3:488. [doi: 10.4103/jehp.jehp_1329_23](https://doi.org/10.4103/jehp.jehp_1329_23).
9. Greenwood, B. (n.d.). *What are the primary roles of the community nurse?* CHRON. <https://work.chron.com/primary-roles-community-nurse-15144.html>
10. National Academy of Medicine. (2021). *The future of nursing 2020-2030: Charting a path to achieve health equity* [PDF Report].

community health nurses pursue health equity. **Health equity** means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing potential obstacles to obtaining and maintaining optimal health such as lack of access to health care services, good jobs with fair pay, quality education and housing, and safe environments.¹¹ Community health nurses address these conditions that are also known as social determinants of health.

Social determinants of health (SDOH) are the conditions in which people are born, grow, work, live, and age. Research shows that the SDOH can be more important than health care or lifestyle choices in influencing health and account for 30-55% of health outcomes.¹² See an illustration of SDOH in Figure 16.4.¹³ SDOH can contribute to **health inequities**, defined as avoidable differences in health status seen within and between communities. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health. According to the

<https://www.phnurse.org/assets/docs/FON%20Valuing%20Community%20and%20Public%20Health%20Nursing.pdf>

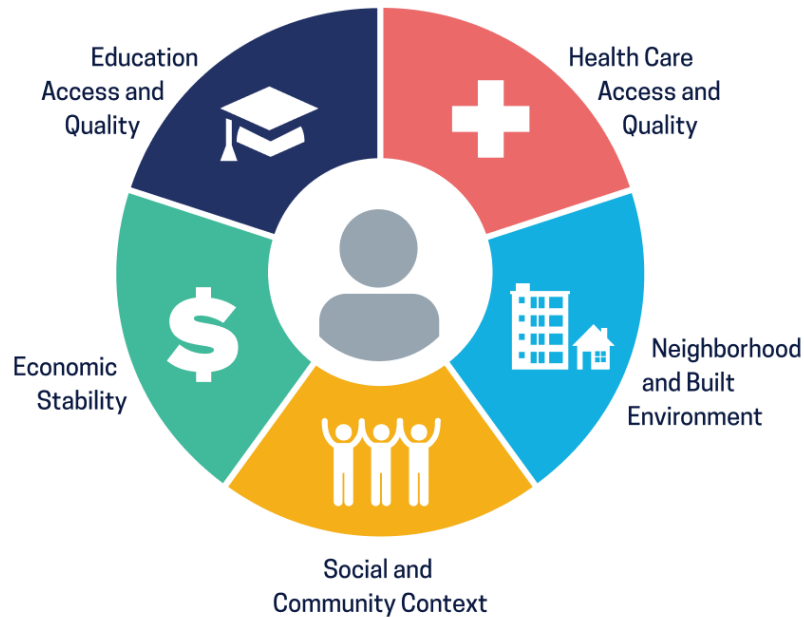
11. Braveman, P., Arkin, E., Orleans, T., Proctor, D., & Plough, A. (2017, May 1). *What is health equity?* Robert Wood Johnson Foundation. <https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html>
12. World Health Organization. (n.d.). *Social determinants of health*. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1
13. "Healthy People 2030 SDOH Graphic.png" by [U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion](#) is in the [Public Domain](#). Access for free at <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>

World Health Organization, SDOH can influence health equity in positive and negative ways¹⁴ :

- Income and social protection
- Education
- Unemployment and job insecurity
- Working life conditions
- Food insecurity
- Housing, basic amenities, and the environment
- Early childhood development
- Social inclusion and nondiscrimination
- Structural conflict
- Access to affordable health services of decent quality

14. World Health Organization. (n.d.). *Social determinants of health*.
https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

Social Determinants of Health



Social Determinants of Health
Copyright-free

Healthy People 2030

Figure 16.4 Social Determinants of Health

Health disparities are health differences that are linked with social, economic, and/or environmental disadvantages. Health disparities adversely affect groups of people who often experience greater obstacles to health based on individual characteristics such as socioeconomic status, age, gender, culture, religion, mental illness, disability, sexual orientation, or gender identity.¹⁵ These groups are often referred to as “vulnerable groups,” and their care is further discussed in the “[Vulnerable Populations](#)” chapter.

Community health nurses aim to promote health equity by addressing social determinants of health (SDOH), health disparities, and inequities in the

15. HealthyPeople.gov. (2022, February 6). *Disparities*. Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services. <https://odphp.health.gov/healthypeople>

communities they serve. They begin by assessing the community context, as it influences how members respond to public health initiatives. Key community context factors include:

- **Physical aspects:** Consider the geographic and man-made features present in the community. How do these features influence residents' access to healthcare and essential services, as well as the community health nurse's ability to reach those residents?
 - Example: Is the community rural, requiring residents to travel long distances for medical care?
- **Infrastructure:** Assess the condition of local roads, bridges, and public transit options, as well as the availability of utilities like internet, electricity, and cellular service.
 - Example: Are buses or rideshare services available for residents to reach healthcare facilities?"
- **Patterns of settlement, commerce, and industry:** Examine how residential and commercial areas are distributed. Are there neighborhoods located near heavy industry, areas with higher crime rates or defined by economic status?
 - Example: Is there a residential area adjacent to a factory that may contribute to air pollution?"
- **Demographics:** Evaluate key population characteristics such as age, gender, race, ethnicity, language, and household composition.
 - Example: Does the community feature multi-generational households?
- **History:** Reflect on the historical events and traditions that shape community identity.
 - Example: Are there monuments or parks that honor local historical events or figures?

- **Community leaders, both informal and formal:** Understand the shared norms, traditions, and values that guide behavior in the community.
 - Example: Is there an annual celebration or parade that reinforces community identity?
- **Community culture, both informal and formal:** What are the spoken and unspoken rules and traditions of the community?
 - For example, does the community have a tradition of celebrating Memorial Day with a parade and public tributes at a local cemetery?
- **Existing groups and organizations:** Consider the presence of local clubs, community centers, and organizations that can facilitate collaboration and support.
 - Example: Is there a YMCA or similar organization promoting physical activity?
- **Existing institutions:** Identify essential institutions—such as hospitals, clinics, schools, libraries, and religious centers—and assess their accessibility and leadership.
 - Example: Is there an urgent care clinic easily accessible by public transit?
- **Economics:** Review the community's economic base, including predominant industries and employment patterns, as well as wealth distribution.
 - Example: Is the area predominantly working class, with most residents employed in local factories?
- **Government/Politics:** Consider the influence and engagement of political leaders and the nature of governance in the community.
 - Example: How does the mayor communicate with residents?
- **Social structure:** Analyze how community members interact on a daily

basis, including conflict resolution and symbols of respect.

- Example: Does the town board meet regularly to discuss local issues and make decisions collaboratively?
- **Attitudes and values:** Investigate what the community prioritizes and any prevailing assumptions or biases regarding behavior and interaction.
 - Example: Is it commonly expected that neighbors will help each other during community challenges, such as after a storm?

According to the CDC, a **healthy community** is one in where local groups work together to prevent disease and promote healthy living. This approach benefits the largest number of people and helps reduce health disparities caused by differences in income, education, race, location, and other factors.¹⁶

Community Health Needs Assessment

Community health needs assessment is a systematic process to identify and analyze community health needs and assets in order to prioritize these needs, plan, and act upon significant unmet community health needs.¹⁷ A community health assessment gives nurses and community organizations comprehensive information about the community's current health status, needs, and issues. This information can be used to develop a community health improvement plan by justifying how and where resources should be

16. Centers for Disease Control and Prevention. (2015, September 18). *A healthy community is a prepared community*. [Blog]. <https://blogs.cdc.gov/publichealthmatters/2015/09/a-healthy-community-is-a-prepared-community/>

17. Vigna, A. J. (2020). *The 2019 behavioral health gaps report for the state of Wisconsin*. University of Wisconsin Population Health Institute. <https://uwphi.pophealth.wisc.edu/publications-2/evaluation-reports-2/>

allocated to best meet community needs.¹⁸ Community health needs assessments are performed and reported at national, state, county, and local levels.

National Health Needs Assessments

Healthy People 2030 addresses the most current national public health priorities. It is published by the United States Department of Health and Human Services Office of Disease Prevention and Promotion. See Figure 16.5¹⁹ for an illustration related to using Healthy People 2030 objectives and leading health indicators to assess community needs data, plan, and evaluate community health interventions.

18. VHA Inc., & Healthy Communities Institute. (2013). *Assessing & addressing community health needs*. Catholic Heart Association of the United States. https://www.chausa.org/docs/default-source/general-files/cb_assessingaddressing-pdf.pdf?sfvrsn=4

19. "HP2030_HowtoUse_Screen1_2020-03-24.png" by unknown author for [U.S. Department of Health and Human Services](https://www.hhs.gov/) is in the [Public Domain](https://www.hhs.gov/). Access for free at <https://health.gov/our-work/national-health-initiatives/healthy-people/healthy-people-2030/promoting-healthy-people-2030>.

How can I use Healthy People 2030 in my work?

Healthy People addresses public health priorities by setting national objectives and tracking them over the decade. Join us as we work to improve health and well-being nationwide.



Healthy People 2030



ODPHP

Office of Disease Prevention
and Health Promotion

Figure 16.5 Healthy People 2030

A set of evidence-based Healthy People objectives are published every ten years based on current national data. Objectives are classified by categories²⁰:

- Health Conditions
- Health Behaviors
- Populations
- Settings and Systems
- Social Determinants of Health

Examples of Healthy People 2030 community objectives include the following²¹:

20. Office of Disease Prevention and Health Promotion. *Healthy People 2030: Building a healthier future for all*. U.S. Department of Health and Human Services. <https://health.gov/healthypeople>
21. Office of Disease Prevention and Health Promotion. *Healthy People 2030: Building a healthier future for all*. U.S. Department of Health and Human Services. <https://health.gov/healthypeople>

- Increase the number of community organizations that provide preventative services
- Increase the rate of bystander CPR and AED use for nontraumatic cardiac arrests in public places
- Increase the proportion of adult stroke survivors who participate in rehabilitation services

Leading Health Indicators (LHIs) are a subset of high-priority Healthy People 2030 objectives to drive action toward improving health and well-being. Most LHIs address important factors that impact major causes of death and disease in the United States. They help organizations, communities, and community health nurses focus their resources and efforts to improve the health and well-being of all people. There are 23 LHIs that cover the life span from infants, children, adolescents, adults, and older adults. See a list of LHIs in Table 16.2.

Table 16.2 Leading Health Indicators Across the Life Span

Life Stage	Leading Health Indicator
Infant	• Infant Death
Children and Adolescents	• 4th grade students whose reading skills are at or above the proficient achievement level for their grade • Adolescents with major depressive episodes (MDEs) who receive treatment • Children and adolescents with obesity • Current use of any tobacco products among adolescents

**Adults and
Older Adults**

- Adults engaging in binge drinking of alcoholic beverages during the past 30 days
- Adults who meet current minimum guidelines for aerobic physical activity and muscle-strengthening activity
- Adults who receive a colorectal cancer screening based on the most recent guidelines
- Adults with hypertension whose blood pressure is under control
- Cigarette smoking in adults
- Employment among the working-age population
- Maternal deaths
- New cases of diagnosed diabetes in the population

All Ages	• Children, adolescents, and adults who use the oral health care system (2+ years) • Consumption of calories from added sugars by persons aged 2 years and over • Drug overdose deaths • Exposure to unhealthy air • Homicides • Household food insecurity and hunger • Persons who are vaccinated annually against seasonal influenza • Persons who know their HIV status (13+ years) • Persons with medical insurance (<65 years) • Suicides

Healthy People 2030 Resources

- ▶ View [Healthy People 2030 Objectives](#), [Community Objectives](#), and [Leading Health Indicators](#).

State Needs Assessments

States perform health needs assessments to develop state funding and

program priorities for community health. For example, the Wisconsin Department of Health Services (DHS) performs a mental health and substance abuse needs assessment every other year. Data in this report includes the following:

- **Prevalence of Needs:** The prevalence of disorders, conditions, and associated problems for the entire population and subpopulations
- **Access to Services:** Determination of which and how many services are received by individuals and exploration of barriers to access
- **Service Workforce and Capacity:** Examination of the mental health and substance use services workforce, including the number of providers of these services and the geographic dispersion of the workforce across the state

Another example of a state needs assessment related to mental health is the Behavioral Health Gaps Study funded by the Wisconsin DHS to assess gaps and needs in the behavioral health service system for individuals with mental health and substance use disorders. Key gaps documented in this study included shortages in child and geriatric psychiatrists; shortages in mental health inpatient beds and residential facilities for treating substance use; inadequacies of the medical transportation system; a need for improving crisis stabilization services in the community that focus on reducing contact with police officers; shortages in medication-assisted treatment providers and clinics; long waitlists across the service array; shortages in competent translation services; and the need to provide wraparound services, particularly for consumers with families.²²

22. Vigna, A. J. (2020). *The 2019 behavioral health gaps report for the state of Wisconsin*. University of Wisconsin Population Health Institute.
<https://uwphi.pophealth.wisc.edu/publications-2/evaluation-reports-2/>

Explore your state's health needs assessments. Examples of health needs assessments in the state of Wisconsin are as follows:

- ▶ Department of Health Service's [Mental Health and Substance Abuse Needs Assessment PDF](#)
- ▶ [The Behavioral Health Gaps Report for the State of Wisconsin PDF](#) completed by University of Wisconsin-Madison Population Health Institute

County Health Rankings

County health rankings are created annually by the University of Wisconsin Population Health Institute for counties across the country.²³ These rankings provide a snapshot of a community's health and can be used as a starting point for implementing change to promote health equity in communities. See the following box to explore the health ranking for your community.

- ▶ Visit the [Explore Health Rankings](#) web page from the University of Wisconsin Population Health Institute to view the health ranking of your community.

23. Vigna, A. J. (2020). *The 2019 behavioral health gaps report for the state of Wisconsin*. University of Wisconsin Population Health Institute. <https://uwphi.pophealth.wisc.edu/publications-2/evaluation-reports-2/>

Local Needs Assessments

Local communities perform health needs assessments and develop specific health initiatives for their community members. For example, the Eau Claire County Health Department Needs Assessment was used to create a county health plan. In 2021 the top health priorities were documented as drug use, mental health, alcohol misuse, obesity, and healthy nutrition. See Figure 16.6²⁴ with an image related to data from a county mental health needs assessment.

Why is Mental Health a problem in our county?

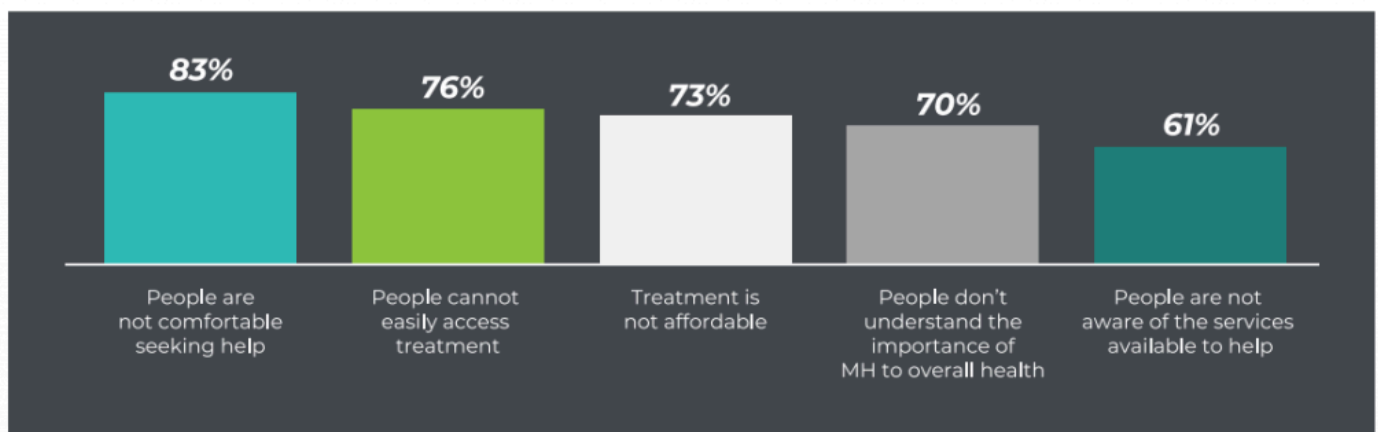


Figure 16.6 Mental Health Assessment

- ▶ Explore your community's health initiatives. View the example of [Eau Claire City-County Health Department Needs Assessment](#).

24. This image is derived from [2021 Eau Claire County Community Health Assessment](#) by Community Health Assessment Planning Partnership Committee and is in the [Public Domain](#)

Hospitals' Community Health Needs Assessments

Tax-exempt hospitals are required to conduct community health needs assessments according to the Patient Protection and Affordable Care Act (i.e., the Affordable Care Act). Hospitals are required to adopt implementation strategies to meet the community health needs identified through their needs assessment. This collaboration among hospitals and community partners expands the community's capacity to address health needs through a shared vision and creates a foundation for coordinated efforts to improve community health.²⁵

25. VHA Inc., & Healthy Communities Institute. (2013). *Assessing & addressing community health needs*. Catholic Heart Association of the United States. https://www.chausa.org/docs/default-source/general-files/cb_assessingaddressing-pdf.pdf?sfvrsn=4

16.3 Applying the Nursing Process to Community Health

Community health nurses apply the nursing process to address needs of individuals, families, vulnerable populations, and entire communities. See Figure 16.7¹ for an illustration of the nursing process in community health nursing.



Figure 16.7 Nursing Process in Community Health Nursing

Assessment (Recognizing Cues)

The community health nurse typically begins a community health needs assessment by determining what data is already available.² As previously

1. "[Nursing Process in Community Health Nursing](#)" by [Open RN](#) project is licensed under [CC BY 4.0](#)
2. [Community Tool Box](#) by [Center for Community Health and Development](#) at the University of Kansas is licensed under [CC BY NC SA 3.0](#)

discussed in the “[Community Health Concepts](#)” section, national, state, county, and local health needs assessments are widely available. **Secondary analysis** refers to analyzing previously collected data to determine community needs.

Community health nurses may also engage in primary data collection to better understand the community needs and/or study who may be affected by actions taken as a result of the assessment.³ **Primary data collection** includes tools such as public forums, focus groups, interviews, windshield surveys, surveys, and participant observation.

Public Forums

Public forums are gatherings where large groups of citizens discuss important issues at well-publicized locations and times. Forums give people of diverse backgrounds a chance to express their views and enhance understanding of the community’s specific needs and resources. Forums should be planned in a convenient location with accessibility to public transportation and child care. They should also be scheduled at convenient times for working families to gain participation from a wide range of populations.

Focus Groups

Focus groups are a systematic method of data collection through small-group discussions led by a facilitator. Participants in focus groups are selected to represent a larger group of people. Groups of 6-10 people with similar backgrounds or interests are interviewed in an informal or formal setting. Focus groups should be scheduled at several dates and times to ensure a

3. [Community Tool Box](#) by [Center for Community Health and Development](#) at the University of Kansas is licensed under [CC BY NC SA 3.0](#)

broad participation from members of the community. Here are advantages of focus groups:

- Community member involvement in assessing and planning community initiatives is encouraged.
- Different perceptions, values, and beliefs by community members are explored.
- Input can be obtained from specific subpopulations of the community. Examples of subpopulations include young mothers caring for infants, individuals receiving home hospice care, individuals struggling to find housing, residents of the prison system, individuals coping with mental health disorders, or residents in group homes.

Interviews

Interviews are structured conversations with individuals who have experience, knowledge, or understanding about a particular topic or issue.

Key informant interviews are conducted with people in key positions in the community and have specific areas of knowledge and experience. These interviews can be useful for exploring specific community problems and/or assessing a community's readiness to address those problems.⁴

Advantages of interviews include the following⁵:

- They can be conducted in a variety of settings (e.g., homes, schools, churches, stores, or community centers).

4. [A Guide to SAMHSA's Strategic Prevention Framework PDF](#) by [Substance Abuse and Mental Health Services Administration](#) is available in the [Public Domain](#).

5. [A Guide to SAMHSA's Strategic Prevention Framework PDF](#) by [Substance Abuse and Mental Health Services Administration](#) is available in the [Public Domain](#).

- They are low cost and generally have low dropout rates.
- Respondents define what is important from their perspective.
- It is possible to explore issues in depth, and there is an opportunity to clarify responses.
- They can provide leads to other data sources and key informants.
- They provide an opportunity to build partnerships with community members.
- Data can be compared among local government officials, citizens, and non-government leaders.

Interviews can have these disadvantages:

- Interviews can be time-consuming to schedule and perform.
- They require trained interviewers.
- There is a potential for interviewer bias to affect the data collected during the interview.
- Rapport must be established before sensitive information is shared.
- It is more time-consuming to summarize and analyze findings.

Windshield Surveys

A **windshield survey** is a type of direct observation of community needs while driving and literally looking through the windshield. It can be used to observe characteristics of a community that impact health needs such as housing, pollution, parks and recreation areas, transportation, health and social services agencies, industries, grocery stores, schools, and religious institutions.



View the following YouTube video of a windshield survey⁶:
[Windshield Survey Nursing](https://youtu.be/aAzW1bW_Dbw).

Surveys

Surveys use standardized questions that are relatively easy to analyze. They are beneficial for collecting information across a large geographic area, obtaining input from as many people as possible, and exploring sensitive topics.⁷ Surveys can be conducted face to face, via the telephone, mailed, or shared on a website. Responses are typically anonymous but demographic information is often collected to focus on the needs of specific populations. Disadvantages of surveys can include the following⁸:

- Surveys can be time-consuming to design, implement, and analyze the results.
- The accuracy of survey results depends on who is surveyed and the size of the sample.
- Mailed surveys may have low response rates with higher costs due to postage.

6. Medrea, R. (2014, July 20). *Windshield survey nursing* [Video]. YouTube. All rights reserved. https://youtu.be/aAzW1bW_Dbw

7. McDonald, L. (2006). *Florence Nightingale and public health policy: Theory, activism and public administration*. University of Guelph. <https://cwfn.uoguelph.ca/nursing-health-care/fn-and-public-health-policy/>

8. [A Guide to SAMHSA's Strategic Prevention Framework PDF](#) by Substance Abuse and Mental Health Services Administration is available in the [Public Domain](#).

- They offer little opportunity to explore issues in depth, and questions cannot be clarified.
- There is no opportunity to build rapport with respondents.

Participant Observation

Participant observation refers to nurses informally collecting data as a member of the community in which they live and work. This is considered a subjective observation because it is from the nurse's perspective. Informal observations are made, or discussions are elicited among peers and neighbors within the community.

Sociocultural Considerations

When analyzing community health needs, it is essential to do so through a sociocultural lens. Just as an individual's health can be influenced by a wide variety of causes, community health problems are affected by various factors in the community. For example, a high rate of cancer in one community could be related to environmental factors such as pollution from local industry, but in another community, it may be related to the overall aging of the population. Both communities have a high rate of cancer, but the public health response would be very different. Another example related to mental health is related to various situational factors affecting depression. A high rate of depression in one community may be related to socioeconomic factors such as low-paying jobs, lack of support systems, and poor access to basic needs like grocery stores, whereas in another community it may be related to lack of community resources during frequent weather disasters. The public health response would be different for these two communities.

Nurses must also recognize and value cultural differences such as health beliefs, practices, and linguistic needs of diverse populations. They must take steps to identify subpopulations who are vulnerable to health disparities and further investigate the causes and potential interventions for these disparities. For example, mental health disparities pose a significant threat to

vulnerable populations in our society, such as high rates of suicide among LGBTQ+ youth, reduced access to prevention services among people living in rural areas, and elevated rates of substance misuse among Native Americans. These disparities threaten the health and wellness of these populations.⁹

Key points to consider when assessing a community using a sociocultural lens include the following:

- Have the trends of assessment data changed over time? What are the potential causes for these changes in this community?
- How does the community's needs assessment data compare to similar communities at local, county, state, and national levels? What target goals and health initiatives have been successfully implemented in other communities?
- What vulnerable subpopulations are part of this community, and what health disparities are they experiencing? What are potential causes and solutions for these health disparities?
- Input from members of vulnerable subpopulations must be solicited regarding their perspectives on health disparities, as well as barriers they are experiencing in accessing health care.

Diagnosis (Analyze Cues)

Similar to how nurses individualize nursing diagnoses for clients based on priority nursing problems identified during a head-to-toe assessment, community health nurses use community health needs assessment data to develop community health diagnoses. These diagnoses are broad, apply to larger groups of individuals, and address the priority health needs of the community. Resources such as Healthy People 2030 can be used to determine current public health priorities.

9. [A Guide to SAMHSA's Strategic Prevention Framework PDF](#) by [Substance Abuse and Mental Health Services Administration](#) is available in the [Public Domain](#).

A **community diagnosis** is a summary statement resulting from analysis of the data collected from a community health needs assessment.¹⁰ A clear statement of the problem, as well as causes of the problem, should be included. A detailed community diagnosis helps guide community health initiatives that include nursing interventions.

A community diagnosis can address health deficits or services that support health in the community. A community diagnosis may also address a need for increased wellness in the community. Community diagnoses should include these four parts:

- The problem
- The population or vulnerable group
- The effects of the problem on the population/vulnerable group
- The indicators of the problem in this community

Here are some examples of community health diagnoses based on community health needs assessments:

- **Community Scenario A**

- **Assessment data:** The local high school has had a 50% increase in the number of teen pregnancies in the past year, causing high school graduation rates to decrease due to pregnant students dropping out of high school.
- **Community diagnosis:** Increased need for additional birth control and resources for prevention of pregnancy due to lack of current resources, as evidenced by 50% increase in teen pregnancies in the last year and a decrease in graduation rates.

10. Office of Disease Prevention and Health Promotion. *Healthy People 2030: Building a healthier future for all*. U.S. Department of Health and Human Services. <https://health.gov/healthypeople>

- **Community Scenario B**

- **Assessment data:** Fifty percent of residents of an assisted living facility were found to have blood pressure readings higher than 130/80 mmHg during a health fair last week at the facility.
- **Community diagnosis:** Increased need for education about exercise and diet and referrals to primary care doctors for residents of an assisted living facility due to increased risk for mortality related to high blood pressure, as evidenced by a high number of residents with high blood pressure during a health fair.

- **Community Scenario C**

- **Assessment data:** The local high school has had two cases of suicide in the past year.
- **Diagnosis:** Increased need for community education regarding suicide prevention and crisis hotlines, as evidenced by an increase in adolescent suicide over the past twelve months.

Outcome Identification (Generate Solutions)

Outcomes refer to the changes in communities that nursing interventions and prevention strategies are intended to produce. Outcomes include broad overall goals for the community, as well as specific outcomes referred to as “SMART” outcomes that are specific, measurable, achievable, realistic, and with a timeline established.

Broad goals for communities can be tied to national objectives established by Healthy People 2030, as previously discussed in the “[Community Health Concepts](#)” section.

Healthy People objectives are classified by these five categories¹¹:

- Health Conditions
- Health Behaviors
- Populations
- Settings and Systems
- Social Determinants of Health

SMART outcomes can be created based on the objectives listed under each category. For example, if an overall community goal is related to “Drug and Alcohol Use” under the “Health Behaviors” category, a SMART outcome could be based on the Healthy People objective, “Increase the proportion of people with a substance use disorder who got treatment in the past year.”¹² Based on this Healthy People objective, an example of a SMART outcome could be the following:

- The proportion of people treated for a substance disorder in Smith County will increase to 14% within the next year.

▶ View the [Healthy People 2030 Objectives](#) and [Community Objectives](#).

11. Office of Disease Prevention and Health Promotion. *Healthy People 2030: Building a healthier future for all*. U.S. Department of Health and Human Services. <https://health.gov/healthypeople>

12. Office of Disease Prevention and Health Promotion. *Healthy People 2030: Building a healthier future for all*. U.S. Department of Health and Human Services. <https://health.gov/healthypeople>

Planning (Generate Solutions)

Nursing interventions for the community can be planned based on the related Healthy People category and objective. For example, based on the sample SMART outcome previously discussed, a planned nursing intervention could be the following:

- The nurse will provide education and materials regarding evidence-based screening practices for substance use disorder in local clinics.

Community health nursing interventions typically focus on prevention of illness with health promotion interventions. After performing a community health needs assessment, identifying priority problems, and establishing health goals and SMART outcomes, the nurse integrates knowledge of health disorders (e.g., diabetes, cancer, obesity, or mental health disorders) and current health risks in a community to plan prevention interventions.

There are two common public health frameworks used to plan prevention interventions. A traditional preventive framework is based on primordial, primary, secondary, tertiary, or quaternary prevention interventions. A second framework, often referred to as the Continuum of Care Prevention Model, was established by the Institute of Medicine (IOM) and includes universal, selected, and indicated prevention interventions. Both frameworks are further discussed in the following sections.¹³

Primordial, Primary, Secondary, Tertiary, and Quaternary Interventions

Preventive health interventions may include primordial, primary, secondary, tertiary, and quaternary prevention interventions. These strategies attempt to

13. Savage, C. L. (2020). *Public/community health and nursing practice: Caring for populations* (2nd ed.). FA Davis.

prevent the onset of disease, reduce complications of disease that develops, and promote quality of life.¹⁴

PRIMORDIAL PREVENTION

Primordial prevention consists of risk factor reduction strategies focused on social and environmental conditions that affect vulnerable populations. In other words, primordial prevention interventions target underlying social determinants of health that can cause disease. These measures are typically promoted through laws and national policy. An example of a primordial prevention strategy is improving access to urban neighborhood playgrounds to promote physical activity in children and reduce their risk for developing obesity, diabetes, and cardiovascular disease.¹⁵ See Figure 16.8¹⁶ for an image of a neighborhood playground.

14. This work is a derivative of [StatPearls](#) by Kisling and Das and is licensed under [CC BY 4.0](#)

15. This work is a derivative of [StatPearls](#) by Kisling and Das and is licensed under [CC BY 4.0](#)

16. "[Playground at Hudson Springs Park.jpg](#)" by [Kevin Payravi](#) is licensed under [CC BY-SA 3.0](#)



Figure 16.8 Primordial Prevention: Neighborhood Playgrounds

PRIMARY PREVENTION

Primary prevention consists of interventions aimed at susceptible populations or individuals to prevent disease from occurring. An example of primary prevention is immunizations.¹⁷ Nursing primary prevention interventions also include public education and promotion of healthy behaviors.¹⁸ See Figure 16.9¹⁹ for an image of an immunization clinic sponsored by a student nurses' association.

17. This work is a derivative of [StatPearls](#) by Kisling and Das and is licensed under [CC BY 4.0](#)

18. Savage, C. L. (2020). *Public/community health and nursing practice: Caring for populations* (2nd ed.). FA Davis.

19. "[10442934136_1f910af332_b](#)" by [Lower Columbia College \(LCC\)](#) is licensed under [CC BY_NC-ND 2.0](#)



Figure 16.9 Primary Prevention: An Immunization Clinic

SECONDARY PREVENTION

Secondary prevention emphasizes early detection of disease and targets healthy-appearing individuals with subclinical forms of disease. Subclinical disease refers to pathologic changes with no observable signs or symptoms. Secondary prevention includes screenings such as annual mammograms, routine colonoscopies, Papanicolaou (Pap) smears, as well as screening for depression and substance use disorders.²⁰ Nurses provide education to community members about the importance of these screenings. See Figure 16.10²¹ for an image of a mammogram.

20. This work is a derivative of [StatPearls](#) by Kisling and Das and is licensed under [CC BY 4.0](#)

21. [“US_Navy_021025-N-6498N-001_Mammogram_technician_aids_a_patient_in_completing_her_annual_mammogram_evaluation.jpg”](#) by U.S. Navy photo by Ensign Ann-Marie Al Noad is in the [Public Domain](#).



Figure 16.10 Secondary Prevention: Mammograms

TERTIARY PREVENTION

Tertiary prevention is implemented for symptomatic clients to reduce the severity of the disease and potential long-term complications. While secondary prevention seeks to prevent the onset of illness, tertiary prevention aims to reduce the effects of the disease after it is diagnosed in an individual.²² For example, rehabilitation therapy after an individual experiences a cerebrovascular accident (i.e., stroke) is an example of tertiary prevention. See Figure 16.11²³ for an image of a client receiving rehabilitation after experiencing a stroke.

The goals of tertiary prevention interventions are to reduce disability, promote curative therapy for a disease or injury, and prevent death. Nurses may be involved in providing ongoing home health services in clients' homes as a component of interprofessional tertiary prevention efforts. Health education to prevent the worsening or recurrence of disease is also provided by nurses.

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23. “[tech_zerog.jpg](#)” by unknown author at [Gaylord.org](#) is included on the basis of Fair Use



Figure 16.11 Tertiary Prevention: Post-Stroke Rehabilitation. Used under Fair Use.

QUATERNARY PREVENTION

Quaternary prevention refers to actions taken to protect individuals from medical interventions that are likely to cause more harm than good and to suggest interventions that are ethically acceptable. Targeted populations are those at risk of overmedicalization.²⁴ An example of quaternary prevention is encouraging clients with terminal illness who are approaching end of life to seek focus on comfort and quality of life and consider hospice care rather than undergo invasive procedures that will likely have no impact on recovery from disease.

See additional examples of primordial, primary, secondary, tertiary, and quaternary prevention strategies in Table 16.3a.

24. This work is a derivative of [StatPearls](#) by Kisling and Das and is licensed under [CC BY 4.0](#)

Table 16.3a Examples of Prevention Interventions^{25, 26}

25. Savage, C. L. (2020). *Public/community health and nursing practice: Caring for populations* (2nd ed.). FA Davis.
26. This work is a derivative of [StatPearls](#) by Kisling and Das and is licensed under [CC BY 4.0](#)

Prevention Intervention Strategy	Examples
Primordial Prevention	• Increased tax on cigarettes • Increased access to public walking paths and public parks
Primary Prevention	• Birthing and newborn classes for new parents at the local hospital • Television commercials regarding the importance of the influenza vaccines • Psychosocial health fairs in local malls or other public facilities • Tobacco cessation public education sessions • Television commercials about mindfulness classes at the community center
Secondary Prevention	• Blood pressure screening events • Sexually transmitted disease screening in college students • Mammograms for early detection of breast cancer • Colonoscopies for early detection of colon cancer • Free testing for people exposed to another individual diagnosed with COVID-19 • Screening for substance abuse disorders in high schools • Screening for depression during annual physicals
Tertiary Prevention	• Cardiac rehabilitation for individuals who have experienced a myocardial infarction • Occupational and physical therapy for individuals who experienced a cerebrovascular accident • Diabetic foot care provided at the local community center • Support groups for substance disorders in local churches

Quaternary Prevention	• Routine education provided about advance directives and “Do Not Resuscitate” orders during clinic visits, hospital admissions, and long-term care admissions • Education provided about hospice care to clients diagnosed with terminal illness who are approaching end of life

In the United States, several governing bodies make prevention recommendations. For example, the United States Preventive Services Task Force (USPSTF) makes recommendations for primary and secondary prevention strategies, and the Women’s Preventive Services Initiative (WPSI) makes recommendations specifically for females. The Advisory Committee on Immunizations Practices (ACIP) makes recommendations for vaccinations, and various specialty organizations such as the American College of Obstetrics and Gynecology (ACOG) and the American Cancer Society (ACS) make specialized preventative care recommendations. Preventive services have been proven to be an essential aspect of health care but are consistently underutilized in the United States.²⁷ Nurses can help advocate for the adoption of evidence-based prevention strategies in their communities and places of employment.

Continuum of Care Prevention Model

A second framework for prevention interventions, referred to as the “Continuum of Care Prevention Model,” was originally proposed by the Institute of Medicine (IOM) in 1994 and has been adopted by the Substance

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Abuse and Mental Health Services Administration (SAMHSA).²⁸ See Figure 16.12²⁹ for an illustration of the Continuum of Care Prevention Model.

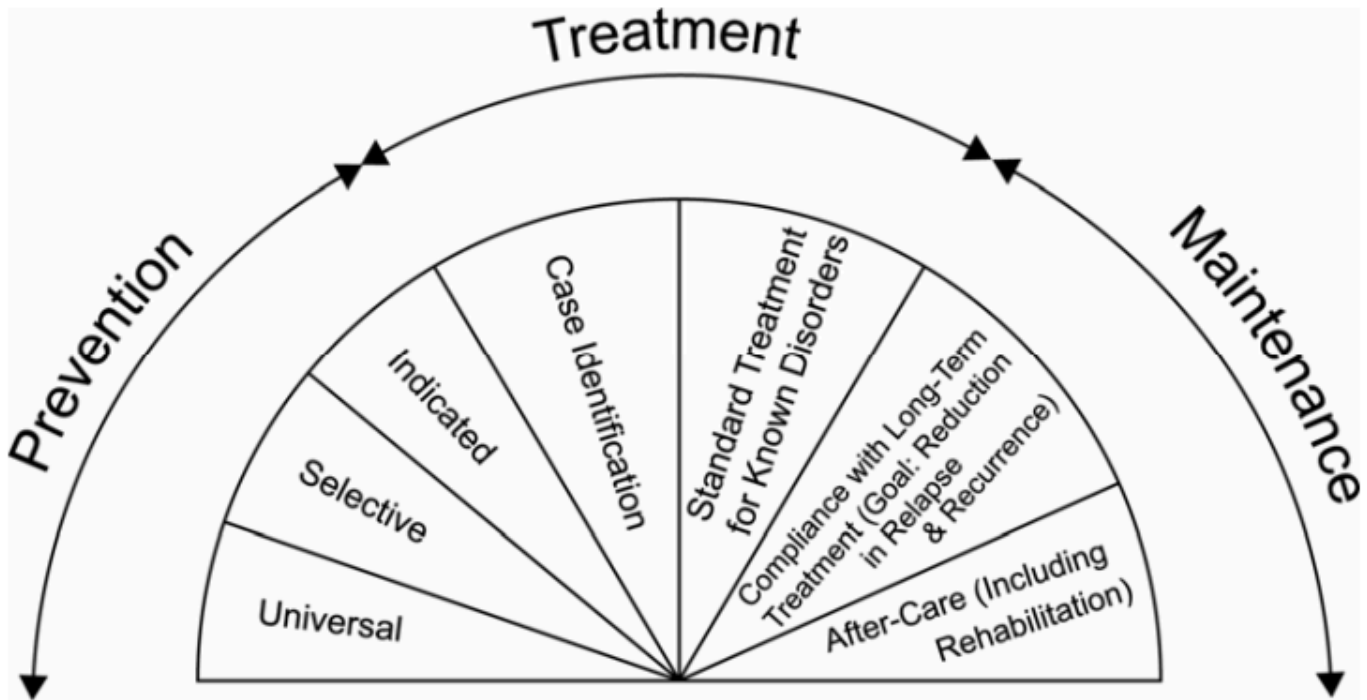


Figure 16.12 Continuum of Care Prevention Model. Used under Fair Use.

The Continuum of Care Prevention Model can be used to illustrate a continuum of mental health services for community members that includes prevention, treatment, and maintenance care:

28. National Research Council (US); Institute of Medicine (US) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults; and Research Advances and Promising Interventions. Defining the scope of prevention. (2009). In M. E. O'Connell & Warner B. T. (Eds). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities. In Research advances and promising interventions*. National Academies Press. <https://www.ncbi.nlm.nih.gov/books/NBK32789/>
29. This image is a derivative of the "IOM protractor" by unknown author and is included on the basis of Fair Use. Access for free at http://www.ca-sdfsc.org/docs/resources/SDFSC_IOM_Policy.pdf

- Prevention includes three types of strategies including universal, selective, and indicated interventions.
 - **Universal prevention:** Interventions designed to reach entire groups, such as those in schools, workplaces, or entire communities.^{30,31} For example, wellness sessions regarding substance misuse can be planned and implemented at a local high school.
 - **Selected prevention:** Interventions that target individuals or groups with greater risk factors (and perhaps fewer protective factors) than the broader population.^{32,33} For example, a research study showed that wellness programs implemented for adolescents who were already

30. National Research Council (US); Institute of Medicine (US) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults; and Research Advances and Promising Interventions. Defining the scope of prevention. (2009). In M. E. O'Connell & Warner B. T. (Eds). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities. In Research advances and promising interventions*. National Academies Press. <https://www.ncbi.nlm.nih.gov/books/NBK32789/>

31. A Guide to SAMHSA's Strategic Prevention Framework PDF by [Substance Abuse and Mental Health Services Administration](#) is available in the [Public Domain](#).

32. National Research Council (US); Institute of Medicine (US) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults; and Research Advances and Promising Interventions. Defining the scope of prevention. (2009). In M. E. O'Connell & Warner B. T. (Eds). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities. In Research advances and promising interventions*. National Academies Press. <https://www.ncbi.nlm.nih.gov/books/NBK32789/>

33. A Guide to SAMHSA's Strategic Prevention Framework PDF by [Substance](#)

using alcohol or drugs reduced the quantity and frequency of their alcohol use and reduced episodes of binge drinking.³⁴

- **Indicated prevention:** Interventions that target individuals who have a high probability of developing disease.³⁵ For example, interventions may be planned for adolescents who show early signs of substance misuse but have not yet been diagnosed with a substance use disorder. Interventions may include referrals to community support services for adolescents who have violated school alcohol or drug policies.³⁶
- Treatment refers to identification of a mental health disorder and standard treatment for the known disorder. Treatment also includes interventions to reduce the likelihood of future co-occurring disorders.³⁷
- Maintenance refers to long-term treatment to reduce relapse and

[Abuse and Mental Health Services Administration](#) is available in the [Public Domain](#).

34. Werch, C., Moore, M. J., DiClemente, C. C., Bledsoe, R., & Jobli, E. (2005). A multihealth behavior intervention integrating physical activity and substance use prevention for adolescents. *Prevention Science*, 6(213). <https://doi.org/10.1007/s11121-005-0012-3>
35. National Research Council (US); Institute of Medicine (US) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults; and Research Advances and Promising Interventions. Defining the scope of prevention. (2009). In M. E. O'Connell & Warner B. T. (Eds). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities. In Research advances and promising interventions*. National Academies Press. <https://www.ncbi.nlm.nih.gov/books/NBK32789/>
36. A Guide to SAMHSA's Strategic Prevention Framework PDF by [Substance Abuse and Mental Health Services Administration](#) is available in the [Public Domain](#).

recurrence, as well as provision of after-care services such as rehabilitation.³⁸

See additional examples of prevention strategies using the Continuum of Care Prevention Model in Table 16.3b.

Table 16.3b Examples of Continuum of Care Prevention Strategies

37. National Research Council (US); Institute of Medicine (US) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults; and Research Advances and Promising Interventions. Defining the scope of prevention. (2009). In M. E. O'Connell & Warner B. T. (Eds). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities. In Research advances and promising interventions*. National Academies Press. <https://www.ncbi.nlm.nih.gov/books/NBK32789/>
38. National Research Council (US); Institute of Medicine (US) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults; and Research Advances and Promising Interventions. Defining the scope of prevention. (2009). In M. E. O'Connell & Warner B. T. (Eds). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities. In Research advances and promising interventions*. National Academies Press. <https://www.ncbi.nlm.nih.gov/books/NBK32789/>

Prevention Strategies	Examples
Universal Prevention	• Handwashing education and posters in bathrooms of community gas stations • Parenting classes for new parents • Flu vaccine clinics at a local church
Selective Prevention	• Backpack-buddy programs that provide food from schools to low-income families on weekends • Concussion training programs for youth athletes and their parents • Contact tracing procedures for individuals diagnosed with COVID-19
Indicated Prevention	• Exercise programs at the local senior center targeted for individuals with diabetes • Food or clothing pantries established in a homeless shelter • Screening and consultation for the families of individuals who are admitted to hospitals with alcohol-related injuries

- Read [A Guide to SAMHSA's Strategic Prevention Framework](#) PDF for more about planning prevention strategies for substance misuse and related mental health problems.

Culturally Competent Interventions

To overcome systemic barriers that can contribute to health disparities, nurses must recognize and value cultural differences of diverse populations and

develop prevention programs and interventions in ways that ensure members of these populations benefit from their efforts.³⁹

SAMHSA identified the following cultural competence principles for planning prevention interventions⁴⁰:

- Include the targeted population in needs assessments and prevention planning
- Use a population-based definition of community (i.e., let the community define itself)
- Stress the importance of relevant, culturally appropriate prevention approaches
- Promote cultural competence among program staff

▶ Review additional concepts related to culturally responsive care in the “[Diverse Patients](#)” chapter of *Open RN Nursing Fundamentals, 2e*.

Evidence-Based Practice

It is essential to incorporate evidence-based practice when planning community health interventions. SAMHSA provides an evidence-based

39. A Guide to SAMHSA’s Strategic Prevention Framework PDF by [Substance Abuse and Mental Health Services Administration](#) is available in the [Public Domain](#).

40. A Guide to SAMHSA’s Strategic Prevention Framework PDF by [Substance Abuse and Mental Health Services Administration](#) is available in the [Public Domain](#).

practice resource center for preventive practices related to mental health and substance abuse. See these resources, as well as examples of evidence-based programs and practices in the following box.

Examples of Evidence Based Prevention Practices related to Mental Health and Substance Misuse⁴¹

- ▶ [Blueprints for Healthy Youth Development](#): Youth violence, delinquency, and drug prevention and intervention programs that meet a strict scientific standard of program effectiveness
- ▶ [Evidence-Based Behavioral Practice \(EBBP\)](#): A project that creates training resources to help bridge the gap between behavioral health research and practice
- ▶ [SAMHSA's Suicide Prevention Research Center \(SPRC\)](#): A best practices registry that identifies, reviews, and disseminates information about best practices that address specific objectives of the National Strategy for Suicide Prevention
- ▶ [The Athena Forum: Prevention 101](#): Substance misuse prevention programs and strategies with evidence of success from the Washington State Department of Social and Health Services
- ▶ [National Institute on Drug Abuse: Preventing Drug Use Among Children and Adolescents PDF](#): Research-based drug abuse

41. Substance Abuse and Mental Health Services Administration. (2019, July 19). *Finding evidence-based programs and practices* [PDF]. https://www.samhsa.gov/sites/default/files/20190719-samhsa-finding_evidence-based-programs-practices.pdf

prevention principles and an overview of program planning, including universal, selected, and indicated interventions

► View the [SAMHSA Evidence-Based Practice Resource Center](#).

Implementation (Take Action)

Community health nurses collaborate with individuals, community organizations, health facilities, and local governments for successful implementation of community health initiatives. Depending on the established community health needs, goals, outcomes, and target group, the implementation of nursing interventions can be categorized as clinical, behavioral, or environmental prevention:

- **Clinical prevention:** Interventions are delivered one-on-one to individuals in a direct care setting. Examples of clinical prevention interventions include vaccine clinics, blood pressure monitoring, and screening for disease.
- **Behavioral prevention:** Interventions are implemented to encourage individuals to change habits or behaviors by using health promotion strategies. Examples of behavioral prevention interventions include community exercise programs, smoking cessation campaigns, or promotion of responsible alcohol drinking by adults.
- **Environmental prevention:** Interventions are implemented for the entire community when laws, policies, physical environments, or community structures influence a community's health. Examples of environmental prevention strategies include improving clean water systems, establishing no-smoking ordinances, or developing community parks and green spaces.

Evaluation (Evaluate Outcomes)

When evaluating the effectiveness of community health initiatives, nurses refer to the established goals and SMART outcomes to determine if they were met by the timeline indicated. In general, the following questions are asked during the evaluation stage:

- Did the health of the community improve through the interventions put into place?
- Are additional adaptations or changes to the interventions needed to improve outcomes in the community?
- What additional changes are needed to improve the health of the community?
- Have additional priority problems been identified?

16.4 Learning Activities



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<https://wtcs.pressbooks.pub/nursingmhcc/?p=733#h5p-53>

1



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<https://wtcs.pressbooks.pub/nursingmhcc/?p=733#h5p-54>

2



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1. “Community Assessment Glossary Cards” by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)
2. “Community Assessment Question Set 1” by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)

online here:

<https://wtcs.pressbooks.pub/nursingmhcc/?p=733#h5p-55>

3

- ▶ Test your clinical judgment with an NCLEX Next Generation-style question: [Chapter 16, Assignment 1](#)⁴



- ▶ Test your clinical judgment with an NCLEX Next Generation-style case study: [Chapter 16, Case Study 1](#)⁵



3. "Community Assessment Drag and Drop" by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)
4. "Community Assessment Next Gen Question 1" by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)
5. "Community Assessment Next Gen Case Study" by Kellea Ewen is licensed under [CC BY-NC 4.0](#)

XVI Glossary

Community diagnosis: A summary statement resulting from analysis of the data collected from a community health needs assessment.

Community health needs assessment: A systematic process to identify and analyze community health needs and assets in order to prioritize these needs, plan, and act upon significant unmet community health needs.

Focus groups: A systematic way of collecting data through small group discussion. Focus group participants are chosen to represent a larger group of people.

Health disparities: Health differences that are linked with social, economic, and/or environmental disadvantages.

Health equity: A goal of everyone having a fair and just opportunity to be as healthy as possible.

Health inequities: Avoidable differences in health status seen within and between communities.

Healthy community: A community in which local groups from all parts of the community work together to prevent disease and make healthy living options accessible.

Indicated prevention: Interventions that target individuals who have a high probability of developing disease.

Interviews: Structured conversations with specific individuals who have experience, knowledge, or understanding about a topic or issue.

Key informant interviews: Interviews are conducted with select people who are in key positions and have specific areas of knowledge and experience.

Leading health indicators (LHIs): A subset of high-priority Healthy People 2030 objectives to drive action toward improving health and well-being.

Primary data collection: Data collected to better understand the community's needs and/or study who may be affected by actions taken for the community. Primary data collection includes tools such as public forums, focus groups, interviews, windshield surveys, surveys, and participant observation.¹

Primary prevention: Interventions aimed at susceptible populations or individuals to prevent disease from occurring. Immunizations are an example of primary prevention.

Primordial prevention: Risk factor reduction strategies focused on social and environmental conditions targeted for vulnerable populations.

Public forums: Public gatherings where citizens discuss important issues at well-publicized locations and times.

Public health nurses: Public health nurses work across various settings in the community such as government agencies, community-based centers, shelters, and vaccine distribution sites.²

Quaternary prevention: Actions taken to protect individuals from medical interventions that are likely to cause more harm than good and to suggest interventions that are ethically acceptable.

School nurse: Provide a specialized practice of nursing which protects and promotes student health, facilitates optimal development, and advances academic success.

1. [Community Tool Box](#) by Center for Community Health and Development at the University of Kansas is licensed under [CC BY NC SA 3.0](#)
2. Greenwood, B. (2018, June 29). *What are the primary roles of the community nurse?* CHRON. <https://work.chron.com/primary-roles-community-nurse-15144.html>

Secondary analysis: Analyzing previously collected data and research about the community to determine community needs.

Secondary prevention: Interventions that emphasize early detection of disease and target healthy-appearing individuals with subclinical forms of disease.

Selected prevention: Interventions that target individuals or groups with greater risk factors for illness (and perhaps fewer protective factors) than the broader population.

Social determinants of health (SDOH): The conditions in which people are born, grow, work, live, and age.

Surveys: Standardized questions that are relatively easy to analyze and are beneficial for collecting information across a large geographic area, hear from as many people as possible, and explore sensitive topics.

Tertiary prevention: Interventions implemented for symptomatic clients to reduce the severity of the disease and potential long-term complications.

Universal prevention: Interventions designed to reach entire groups or populations such as schools, whole communities, or workplaces.

Windshield survey: A form of direct observation of community needs while driving and literally looking through the windshield.

PART XVII

CHAPTER 17 VULNERABLE POPULATIONS

Learning Objectives

- Describe vulnerable populations
- Identify the needs of the populations that impact health-seeking behaviors
- Discuss support systems and organizations available for vulnerable populations
- Describe the role of the nurse as an advocate for vulnerable populations

The “[Community Assessment](#)” chapter describes how to assess community health needs and apply the nursing process to community health nursing. This chapter provides an overview of vulnerable populations and information for the nurse generalist to support their needs.

17.2 Vulnerable Populations

A **vulnerable population** is a group of individuals who are at increased risk for health problems and health disparities.¹ **Health disparities** are health differences linked with social, economic, and/or environmental disadvantages. These disparities disproportionately affect individuals who face greater obstacles to health due to factors such as, such as socioeconomic status, age, gender, culture, religion, mental illness, disability, sexual orientation, or gender identity.²

Examples of vulnerable populations include^{3,4}:

- The very young and the very old
- Individuals with chronic illnesses, disabilities, or communication barriers
- Veterans
- Racial and ethnic minorities
- Individuals who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ)
- Victims of human trafficking or sexual violence
- Individuals who are incarcerated and their family members
- Rural Americans

1. AJMC. (2006, November 1). Vulnerable populations: Who are they? *AJMC*, 12(1). <https://www.ajmc.com/view/nov06-2390ps348-s352>

2. HealthyPeople.gov. (2022, February 6). *Disparities*. Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services. <https://odphp.health.gov/healthypeople>

3. Joszt, L. (2018, July 20). 5 vulnerable populations in healthcare. *The American Journal of Managed Care*. <https://www.ajmc.com/view/5-vulnerable-populations-in-healthcare>

4. AJMC. (2006, November 1). Vulnerable populations: Who are they? *AJMC*, 12(1). <https://www.ajmc.com/view/nov06-2390ps348-s352>

- Migrant workers
- Individuals with chronic mental health disorders
- People experiencing homelessness Homeless people

These individuals often have limited access to healthcare services, resulting in significant health disparities in life expectancy, morbidity, and mortality. They are also more likely to experience one or more chronic physical or mental health conditions.⁵ Advancing health equity for all members of our society is receiving increased emphasis as a central goal of public health. **Health equity** is defined by the U.S. Department of Health and Human Services as the “attainment of the highest level of health for all people” and that “achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequities, historical and contemporary injustices, and the elimination of health and health care disparities.”⁶

Examples of vulnerable populations and associated resources available to promote health equity and reduce health disparities are further described in the following sections.

Age and Developmental Status

Developmental status and age influence vulnerability. Children have unique health and developmental needs that require age-appropriate care. Their dependency on others, developmental changes, and distinct patterns of illness and injury necessitate specialized attention within the healthcare

5. AJMC. (2006, November 1). Vulnerable populations: Who are they? *AJMC*, 12(1). <https://www.ajmc.com/view/nov06-2390ps348-s352>
6. Liburd, L. C., Hall, J. E., Mpofu, J. J., Williams, S. M., Bouye, K., & Penman-Aguilar, A. (2020). Addressing health equity in public health practice: Frameworks, promising strategies, and measurement considerations. *Annual Review of Public Health*, 41(1), 417-432. <https://www.annualreviews.org/doi/10.1146/annurev-publhealth-040119-094119>

system. Similarly, the elderly population faces unique healthcare challenges due to a higher incidence of illness and disability, as well as the complexities of managing multiple chronic conditions and medications.⁷

Both children and the elderly are also at increased risk for neglect and abuse. Nurses must recognize signs of neglect and abuse and are legally mandated to report these signs. Read more about neglect, abuse, and mandatory reporting in the “[Trauma, Abuse, and Violence](#)” chapter.

Chronic Illness and Disability

Individuals with chronic illnesses or disabilities face greater challenges in accessing healthcare services than the general population. These vulnerable groups often encounter barriers such as fragmented care across multiple providers and a lack of care coordination. Additionally, individuals with specific chronic conditions, such as mental illness or HIV, may experience social stigma that impedes their ability to seek or receive appropriate healthcare.⁸ See Figure 17.1⁹ for an image of a disabled individual who is considered a member of a vulnerable population.

7. Advisory Commission on Consumer Protection and Quality in the Health Care Industry. (n.d.). *Chapter eight: Focusing on vulnerable populations*. University of North Texas Libraries and U.S. Government Printing Office.
<https://govinfo.library.unt.edu/hcquality/meetings/mar12/papch08.htm>
8. Advisory Commission on Consumer Protection and Quality in the Health Care Industry. (n.d.). *Chapter eight: Focusing on vulnerable populations*. University of North Texas Libraries and U.S. Government Printing Office.
<https://govinfo.library.unt.edu/hcquality/meetings/mar12/papch08.htm>
9. “[COVID-19 vaccination center, fair grounds Cologne, 1st vaccination-8070.jpg](#)” by Raimond Spekking is licensed under [CC BY-SA 4.0](#)



Figure 17.1 Member of a Vulnerable Population

In addition to experiencing challenges in accessing appropriate health care, adults with disabilities report experiencing more mental distress than the general population. In 2018 an estimated 17.4 million (32.9%) adults with disabilities experienced frequent mental distress, defined as 14 or more reported mentally unhealthy days in the past 30 days. Frequent mental distress is associated with poor health behaviors, mental health disorders, and limitations in daily life.¹⁰ The National Center on Health, Physical Activity and Disability (NCHPAD) is a public health resource center that focuses on health promotion, wellness, and quality of life for people with disabilities.

The Barrier-Free Health Care Initiative is a national initiative by the American Disability Association and the Offices of the United States Attorneys that supports people with disabilities. It legally enforces appropriate access to health care services, such as effective communication for people who are deaf or have hearing loss, physical access to medical care for people with mobility disabilities, and equal access to treatment for people who have HIV/AIDS. This nationwide initiative sends a collective message that disability discrimination in health care is illegal and unacceptable.

10. Centers for Disease Control and Prevention. (2024, December 18). The mental health of people with disabilities.<https://odphp.health.gov/healthypeople>

- ▶ Visit the [Barrier-Free Health Care Initiative](#) to learn more.
- ▶ Visit the [National Center on Health, Physical Activity and Disability \(NCHPAD\)](#) for additional wellness resources.

Veterans

A veteran is someone who has served in the military forces. Veterans have higher risks for mental health disorders, substance use disorders, post-traumatic stress disorders, traumatic brain injuries, and suicide compared to their civilian counterparts. Medical records of veterans reveal that one in three clients was diagnosed with at least one mental health disorder.¹¹ Identifying and treating mental health disorders in veterans have the greatest potential for reducing suicide risk, but the reluctance in this population to seek treatment can make diagnosing and treating mental illness challenging. Nurses must be aware of their clients' military history, recognize risk factors for common disorders, and advocate for appropriate health care services.¹² See Figure 17.2¹³ for an image of a veteran.

11. Olenick, M., Flowers, M., & Diaz, V. J. (2015). US veterans and their unique issues: Enhancing health care professional awareness. *Advances in Medical Education and Practice*, 6, 635–639. <https://doi.org/10.2147/AMEP.S89479>
12. Olenick, M., Flowers, M., & Diaz, V. J. (2015). US veterans and their unique issues: Enhancing health care professional awareness. *Advances in Medical Education and Practice*, 6, 635–639. <https://doi.org/10.2147/AMEP.S89479>
13. “[DF-SD-03-05175](#)” by Scott H. Spitzer, Civilian, USAF is in the [Public Domain](#).



Figure 17.2 Armed Forces Veteran

The Veterans Health Administration (VHA), the largest healthcare network in the United States, provides medical care to eligible veterans through 1,255 facilities, serving approximately nine million enrolled veterans each year. It is important to note that VA healthcare is not health insurance but rather a hospital system offering medical care. While the VA must provide care for service-connected illnesses or injuries, coverage for other conditions varies based on an individual's priority group, medical needs, and eligibility criteria. Some veterans may also qualify for additional benefits such as dental care.

Veterans may also be eligible for non-medical benefits, including education assistance, home loans or housing grants, and life insurance. Nurses can refer veteran clients to the VA for more information about available benefits and enrollment requirements.

Additionally, veterans and their families can access mental health support through the National Alliance on Mental Illness (NAMI) Homefront program. This course is specifically designed for families, caregivers, and friends of service members and veterans with mental health conditions. It provides education on mental health disorders and strategies to improve support for veterans in need.

- ▶ Visit the [Veterans Affairs \(VA\)](#) website for additional information on health care and other benefits for military service members.
- ▶ Visit the [NAMI Homefront](#) course to learn more about mental health conditions and resources available to military service members and their families.

Racial and Ethnic Minorities

Racial and ethnic minority populations in the United States experience significant health disparities.¹⁴ See Figure 17.3¹⁵ for an image of a child from a minority population. The U.S. Department of Health and Human Services Office of Minority Health provides ▶ [Minority Population Profiles](#) for Black/African Americans, American Indian/Alaska Natives, Asian Americans, Hispanic/Latinos, and Native Hawaiian/Pacific Islanders. Profiles include demographics, English language fluency, education, economics, insurance coverage and health status information, and full census reports. Nurses can access these profiles to view health care statistics regarding these populations and services available in their communities.

14. Olenick, M., Flowers, M., & Diaz, V. J. (2015). US veterans and their unique issues: Enhancing health care professional awareness. *Advances in Medical Education and Practice*, 6, 635–639. <https://doi.org/10.2147/AMEP.S89479>

15. “3678466365_da63d01385_b” by [Xavier Donat](#) is licensed under [CC BY-NC-ND 2.0](#)



Figure 17.3 Child of a Minority Population

The Office of Minority Health is dedicated to improving the health of racial and ethnic minority populations through the development of health policies and programs that help eliminate health disparities.

- ▶ Visit the [Office of Minority Health](#) to learn more about efforts to improve the health of racial and ethnic minority populations through health policy and program development. Examples of initiatives include the following¹⁶ :
 - ▶ [COVID-19 Response](#)
 - ▶ [Improving Cultural Competency for Behavioral Health](#)

¹⁶. Olenick, M., Flowers, M., & Diaz, V. J. (2015). US veterans and their unique issues: Enhancing health care professional awareness. *Advances in Medical Education and Practice*, 6, 635–639. <https://doi.org/10.2147/AMEP.S89479>

Professionals

▶ Sickle Cell Disease Initiative

LGBTQ Population

The lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) population encompasses all races and ethnicities, religions, and social classes.

Research suggests that LGBTQ individuals experience health disparities linked to societal stigma, discrimination, and denial of their civil rights.¹⁷ The LGBTQ population experiences high rates of mental health disorders, substance abuse, and suicide, and experiences of violence and victimization are frequent for LGBTQ individuals and can result in long-lasting effects.¹⁸ See Figure 17.4¹⁹ for an image of a pride festival by an LGBTQ population.

17. HealthyPeople.gov. (2022, February 6). *Lesbian, gay, bisexual, and transgender health*. Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services. <https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/lgbt>

18. HealthyPeople.gov. (2022, February 6). *Lesbian, gay, bisexual, and transgender health*. Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services. <https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/lgbt>

19. “[Pride Festival 2013 On The Streets Of Dublin \(LGBTQ\) \(9183775778\).jpg](#)” by [infomatique](#) is licensed under [CC BY-SA 2.0](#)



Figure 17.4 Pride Festival for the LGBTQ Population

Community efforts to improve the health of the LGBTQ population include these initiatives²⁰:

- Training health professionals to appropriately inquire and support clients' sexual orientation and gender identity to promote regular use of health care services
- Training health professionals and students regarding culturally competent care
- Providing supportive social services to reduce suicide and homelessness among LGBTQ youth
- Curbing sexually transmitted infections and human immunodeficiency virus (HIV) transmission

20. HealthyPeople.gov. (2022, February 6). *Lesbian, gay, bisexual, and transgender health*. Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services. <https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/lgbt>

- Discover health services by state at [CDC's LGBT Health website](#).

Human Trafficking Victims

Human trafficking victims are forced to work or provide commercial sex against their will in legal business settings and underground markets.²¹ The International Labor Organization estimates there are 40.3 million victims of human trafficking globally. Victims include men, women, adolescents, and children.²² Experts estimate that 100,000 incidents of sexual exploitation of minors occur each year in the United States.²³ Human trafficking victims have been identified in cities, suburbs, and rural areas in all 50 states and in Washington, D.C. See Figure 17.5²⁴ regarding human trafficking statistics reported by state in 2020.

21. National Human Trafficking Hotline. (n.d.). *The victims*. <https://humantraffickinghotline.org/what-human-trafficking/human-trafficking/victims>
22. National Human Trafficking Hotline. (n.d.). *The victims*. <https://humantraffickinghotline.org/what-human-trafficking/human-trafficking/victims>
23. Office of the Attorney General for the District of Columbia. (n.d.). *Human trafficking initiatives*. <https://oag.dc.gov/public-safety/human-trafficking-initiatives>
24. This image is derived from Human Trafficking Hotline data and is in the [Public Domain](#). Access for free at <https://humantraffickinghotline.org/states>

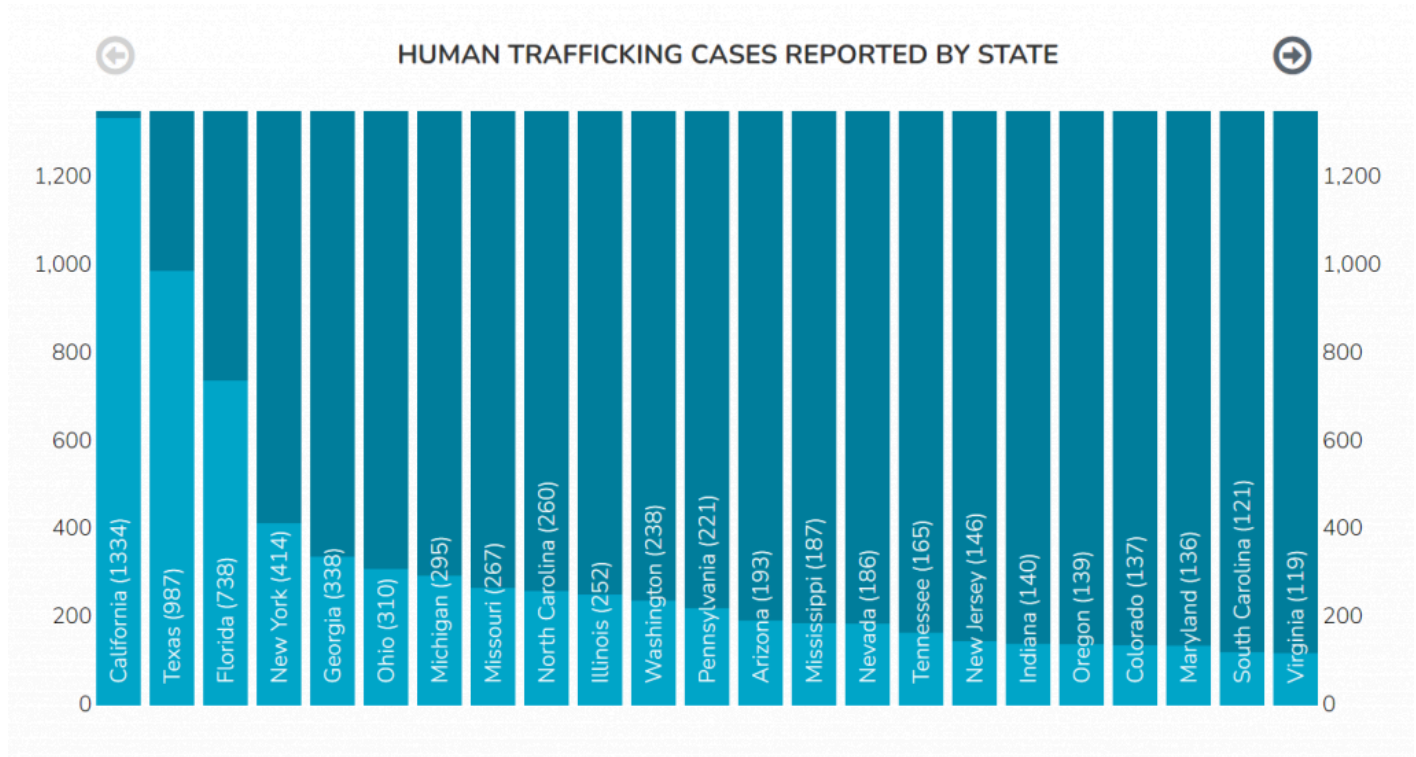


Figure 17.5 Human Trafficking Reported by State in 2020

Widespread lack of awareness and understanding of trafficking leads to low levels of victim identification. Individuals at risk include runaway and homeless youth, foreign nationals, and individuals with prior history of experiencing violence or abuse. A study in Chicago found that 56 percent of female prostitutes were initially runaway youth, and similar numbers have been identified for male populations.²⁵

Foreign nationals who are trafficked within the United States face unique challenges. Recruiters located in home countries frequently require such large recruitment and travel fees that victims become highly indebted to the recruiters and traffickers.

Individuals who have experienced violence and trauma in the past are more vulnerable to future exploitation because the psychological effect of trauma is

25. National Human Trafficking Hotline. (n.d.). *The victims*.

<https://humantraffickinghotline.org/what-human-trafficking/human-trafficking/victims>

often long-lasting and challenging to overcome. Victims of domestic violence, sexual assault, war, or social discrimination may be targeted by traffickers who recognize the vulnerabilities left by these prior abuses.²⁶

These are some of the services victims of trafficking may need²⁷:

- Emergency Services
- Crisis Intervention and Counseling
- Emergency Shelter and Referrals
- Urgent Medical Care
- Safety Planning
- Food and Clothing

► For more information about the services available to victims of human trafficking, visit the [National Human Trafficking Hotline Referral Directory](#).

See an example of a nurse providing care for victims of human trafficking in their community in the “[Spotlight Application](#)” section.

Incarcerated Individuals and Their Families

At the end of 2019, there were over 2 million people in U.S. prisons and jails

26. National Human Trafficking Hotline. (n.d.). *The victims*.
<https://humantraffickinghotline.org/what-human-trafficking/human-trafficking/victims>

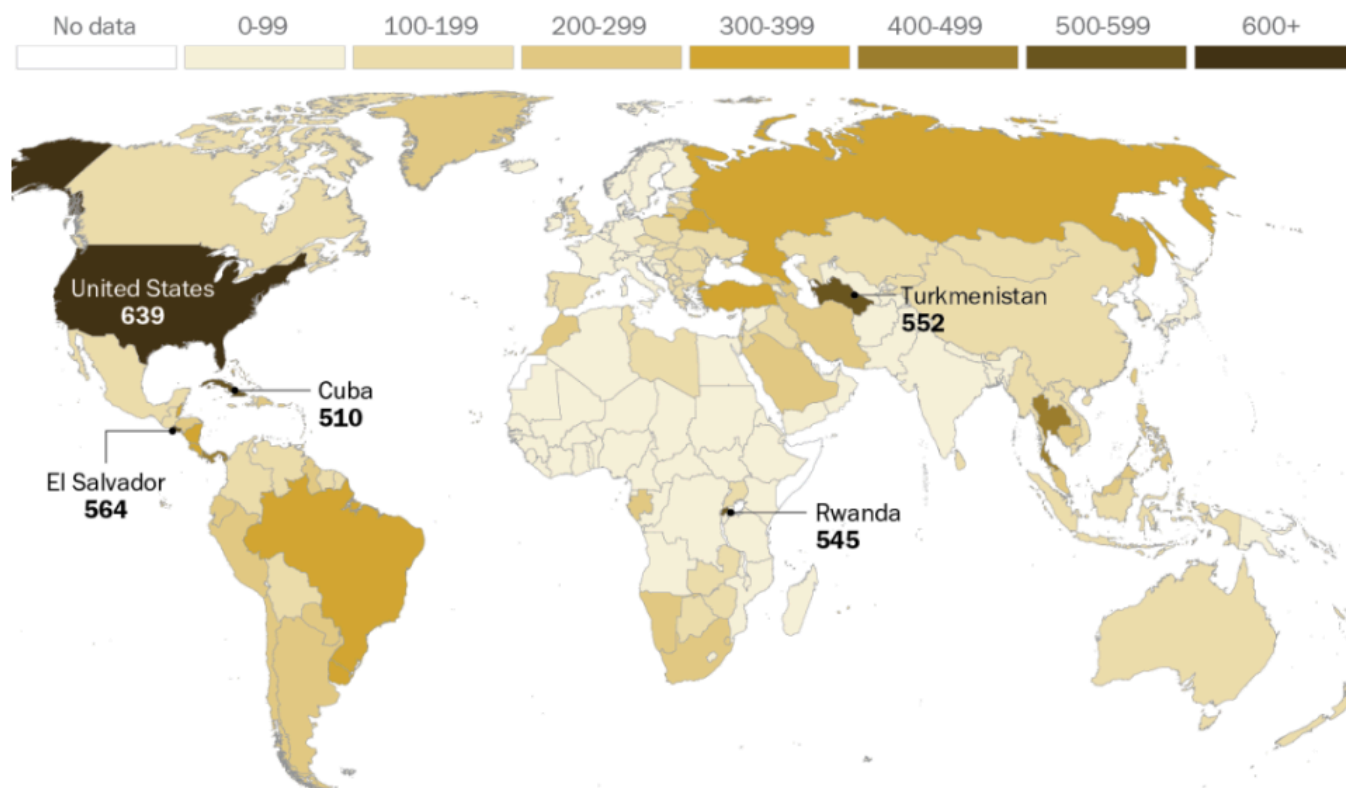
27. National Human Trafficking Hotline. (n.d.). *The victims*.
<https://humantraffickinghotline.org/what-human-trafficking/human-trafficking/victims>

with a nationwide incarceration rate of 810 inmates for every 100,000 adults. Higher rates of incarceration are seen among racial/ethnic minorities and people with lower levels of education. The United States incarcerates a larger share of its population than any other country in the world.²⁸ See Figure 17.6²⁹ for an illustration comparing worldwide incarceration rates.³⁰

28. Gramlich, J. (2021, August 16). *America's incarceration rate falls to lowest level since 1995*. Pew Research Center. <https://pewrsr.ch/2rfSmVL>
29. "U.S. incarcerates a larger share of its population than any other country" by [Pew Research Center](#), Washington, D.C. (August 13, 2021). Used under Fair Use. Access for free at https://www.pewresearch.org/fact-tank/2021/08/16/americas-incarceration-rate-lowest-since-1995/ft_21-08-12_incarceration_2/
30. Rich, J. D., & The Center for Prisoner Health and Human Rights, Miriam Hospital. *Incarceration and health*. [PDF Working paper]. National Academies. https://sites.nationalacademies.org/cs/groups/dbassesite/documents/webpage/dbasse_083371.pdf

U.S. incarcerates a larger share of its population than any other country

Incarceration rate per 100,000 people of any age



Note: Figures reflect most recent available data for each country. Territories are counted separately.

Data accessed Aug. 10, 2021.

Source: World Prison Brief, Institute for Crime & Justice Policy Research.

PEW RESEARCH CENTER

Figure 17.6 Comparison of Worldwide Incarceration Rates. Used under Fair Use.

Many individuals who are incarcerated have chronic health conditions, including mental illness and addiction. Over half of all inmates have a mental health disorder, and female inmates have higher rates of post-traumatic stress disorder (PTSD) than the general population. In fact, some experts believe that escalation of U.S. incarceration rates since the 1970s is associated with inadequate community-based health care for mental illness and addiction; left untreated, both conditions can lead to behaviors that result in incarceration.³¹

31. Rich, J. D., & The Center for Prisoner Health and Human Rights, Miriam Hospital. *Incarceration and health*. [PDF Working paper]. National

Health care is a constitutional right for prisoners. The 1976 Supreme Court decision in *Estelle v. Gamble* found that “deliberate indifference to serious medical needs of prisoners” constitutes a violation of the Eighth Amendment prohibition of cruel and unusual punishment. Nurses working in correctional facilities have a legal and ethical obligation to respond to requests for care. If an inmate’s safety complaints are ignored, safety risks are not removed, or there is failure to provide proper medical attention, it is considered “deliberate indifference.” Correctional nurses have a duty to evaluate prisoners’ health needs and determine the level of care required. For example, the nurse determines if the prisoner should be moved to the medical unit or transferred to a health facility that can provide the level of care needed. In addition, all pertinent information of health encounters with prisoners must be thoroughly documented and include assessment findings, health needs, interventions taken, client education, and evaluation of client outcomes.³²

While the Supreme Court decision mandates health care provision for incarcerated populations in prisons and jails, it does not extend to those under supervision within the criminal justice system (e.g., on parole, probation, or home confinement).³³ However, the Patient Protection and Affordable Care Act (ACA) helps to ensure continuity of medical coverage and care when prisoners are released into the community.³⁴

While mortality rates within prisons and jails are comparable to those of the

Academies. https://sites.nationalacademies.org/cs/groups/dbasse/site/documents/webpage/dbasse_083371.pdf

32. National Commission on Correctional Health Care. (n.d.). *Legal issues*. <https://www.ncchc.org/legal-issues>

33. Gramlich, J. (2021, August 16). *America’s incarceration rate falls to lowest level since 1995*. Pew Research Center. <https://pewrsr.ch/2rfSmVL>

34. Gramlich, J. (2021, August 16). *America’s incarceration rate falls to lowest level since 1995*. Pew Research Center. <https://pewrsr.ch/2rfSmVL>

general population, releasees are nearly 13 times more likely to die in the two weeks following their release than the general population. The most common cause of death is overdose. Interventions that follow in-prison drug treatment programs with post-release treatment have been shown to reduce drug use and associated recidivism (i.e., return to prison). There have also been efforts to improve the outcomes of prisoner reentry to society through assistance with employment, housing, and other transitional needs that ultimately affect health.^{35,36}

- ▶ The National Alliance on Mental Health (NAMI) provides several [Re-Entry Planning](#) resources.

Incarceration has a public health impact on prisoners' family members and their communities while they are incarcerated, as well as after their release. Community health is affected by incarceration due to economic impacts (i.e., consequences on families' well-being when income earners are removed) and long-term impacts on children's health and mental health (also referred to as adverse childhood events). For example, children of incarcerated parents are more likely to live in poverty, as well as have higher rates of learning disabilities, developmental delays, speech/language problems, attention disorders, aggressive behaviors, and drug and alcohol use. Additionally,

35. Rich, J. D., & The Center for Prisoner Health and Human Rights, Miriam Hospital. *Incarceration and health*. [PDF Working paper]. National Academies. https://sites.nationalacademies.org/cs/groups/dbasssite/documents/webpage/dbasse_083371.pdf

36. Massoglia, M., & Pridemore, W. A. (2015). Incarceration and health. *Annual Review of Sociology*, 41, 291–310. <https://doi.org/10.1146/annurev-soc-073014-112326>

children of incarcerated parents are up to five times more likely to enter the criminal justice system than children of non incarcerated parents.³⁷

Family-centered services for incarcerated parents and their children focus on parenting programs, family strengthening activities, nurturing of family relationships, and community support for families during incarceration and following release.

- ▶ Read more about family-centered services at [U.S. Department of Health Services Child Welfare Information Gateway](#).

- ▶ Read additional guidance and resources at [CDC Correctional Health](#).

Rural Americans

Rural Americans are a population group that experiences significant health disparities. Rural risk factors for health disparities include geographic isolation, lower socioeconomic status, higher rates of health risk behaviors, limited access to health care specialists, and limited job opportunities. This inequality is intensified because rural residents are less likely to have

37. Massoglia, M., & Pridemore, W. A. (2015). Incarceration and health. *Annual Review of Sociology*, 41, 291–310. <https://doi.org/10.1146/annurev-soc-073014-112326>

employer-provided health insurance or Medicaid coverage.^{38,39} See Figure 17.7⁴⁰ for an image of a small town in rural America.



Figure 17.7 Rural America

For an in-depth look at rural health disparities, the Rural Health Information Hub Rural Health Series serves as a resource to examine rural mortality and preventable deaths, health-related behaviors, chronic disease, mental health services, and other related topics. The [Federal Office of Rural Health Policy](#) provides additional information regarding rural health policy, community health programs, and telehealth programs to increase access to health care

- 38. Rural Health Information Hub. (2019, April 22). *Rural health disparities*. <https://www.ruralhealthinfo.org/topics/rural-health-disparities>
- 39. United States Department of Agriculture. (2018). Rural America at a glance 2018 edition. *Economic Information Bulletin*, 200. <https://www.ers.usda.gov/publications/pub-details?pubid=90555>
- 40. “[One Light Town” Small Town, Nebraska 7-25-13a \(10784126756\).jpg](#)” by [inkknife_2000](#) (7.5 million views +) is licensed under [CC BY-SA 2.0](#)

for underserved people in rural communities. Two initiatives to improve rural health are the National Health Service Corps (NHSC) loan repayment program and telehealth.⁴¹

NHSC builds healthy communities by supporting health care professionals dedicated to working in areas of the United States with limited access to care. NHSC offers educational loan repayment programs to health professionals who commit to working in underserved areas for specific lengths of time.⁴² See an infographic about NHSC in Figure 17.8.⁴³



Figure 17.8 National Health Service Corps

41. Health Resources & Services Administration. (n.d.). *Federal office of rural health policy*. <https://www.hrsa.gov/rural-health/index.html>
42. National Health Service Corps. *Health Resources & Services Administration*. <https://nhsc.hrsa.gov>
43. This image is derived from [HRSA Programs Serve Rural Communities PDF](#) by Health Resources & Services Administration and is in the [Public Domain](#).

Telehealth is a recent initiative to improve health care access to underserved communities. Telehealth is the use of digital technologies to deliver medical care, health education, and public health services by connecting multiple users in separate locations. See Figure 17.9⁴⁴ for an image of telehealth. Telehealth can improve health outcomes and access to care by delivering health services in underserved areas and remove barriers of time, distance, and provider scarcities.⁴⁵ Nurses support clients using telehealth and provide client education.

However, telehealth can risk widening disparities for some socioeconomic groups with limited access to the resources necessary for effective telemedicine. Nurses can help ensure that health care systems tailor the use of technology to meet the needs of underserved populations.⁴⁶

44. “[Telemedicine_Consult.jpg](#)” by Intel Free Press is licensed under [CC BY-SA 2.0](#)

45. Telligen & Great Plains Telehealth Resource & Assistance Center. (2014). *Telehealth: Start-up and resource guide*. https://www.healthit.gov/sites/default/files/telehealthguide_final_0.pdf

46. Ortega, G., Rodriguez, J. A., Maurer, L. R., Witt, E. E., Perez, N., Reich, A., & Bates, D. W. (2020). Telemedicine, COVID-19, and disparities: Policy implications. *Health Policy and Technology*, 9(3), 368–371. <https://doi.org/10.1016/j.hlpt.2020.08.001>



Figure 17.9 Telehealth

- ▶ Visit the [Rural Health Information Hub Rural Health Series](#) to examine rural mortality and preventable deaths, health-related behaviors, chronic disease, mental health services, and other related topics.
- ▶ Learn more about the [NHSC](#) and how it supports health care professionals to provide care in areas with limited access to health services.

Migrant Workers

A **migrant worker** is a person who moves within their home country or outside of it to pursue work. Migrant workers usually do not intend to stay

permanently in the country or region in which they work. See Figure 17.10⁴⁷ for an image of migrant workers harvesting cabbage.



Figure 17.10 Migrant Workers Harvesting Cabbage

Migratory and seasonal agricultural workers (MASW) and their families face unique health challenges that can result in significant health disparities. Challenges can include the following⁴⁸:

- Hazardous work environments
- Poverty
- Insufficient support systems
- Inadequate or unsafe housing
- Limited availability of clean water and septic systems

47. “5123728839_1b7ce92b5c_k” by Bob Jagendorf is licensed under [CC BY-NC 2.0](#)

48. Rural Health Information Hub. (2021, July 1). *Rural migrant health*.
<https://www.ruralhealthinfo.org/topics/migrant-health>

- Inadequate health care access and lack of continuity of care
- Lack of health insurance
- Cultural and language barriers
- Fear of using health care due to immigration status
- Lack of transportation

MSAW populations experience serious health problems including diabetes, malnutrition, depression, substance use, infectious diseases, pesticide poisoning, and injuries from work-related machinery. These critical health issues are exacerbated by the migratory culture of this population group that increases isolation and makes it difficult to maintain treatment regimens and track health records.⁴⁹

Successful strategies to support health services for migrant workers are as follows⁵⁰ :

- Culturally sensitive health education and outreach
- Educational materials at the appropriate literacy level
- Portable medical records and case management
- Mobile medical units
- Transportation services
- Translation services

▶ In the United States, access to healthcare services for migrant workers can vary depending on several factors, including

49. Rural Health Information Hub. (2021, July 1). *Rural migrant health*. <https://www.ruralhealthinfo.org/topics/migrant-health>

50. Rural Health Information Hub. (2021, July 1). *Rural migrant health*. <https://www.ruralhealthinfo.org/topics/migrant-health>

- ▶ immigration status, employment, and state-specific policies. Nurses can refer uninsured migrant farmworkers to [Migrant Health Centers](#) or other federally qualified health centers that are open to everyone.

- ▶ Read more about promoting migrant worker health at the [Rural Migrant Health Information Hub](#).

Individuals with Mental Health Disorders

One in five American adults experiences some form of mental illness. Despite a recent focus on mental health in America, there are still many harmful attitudes and misunderstandings surrounding mental illness that can cause people to ignore their mental health and make it harder to reach out for help.⁵¹

Many individuals with mental health disorders go undiagnosed. Nurses must be aware of these common signs of mental health disorders⁵²:

- Excessive worrying or fear

51. Centers for Disease Control and Prevention. (2021, July 20). *Mental health*. https://www.cdc.gov/mental-health/?CDC_AAref_Val=https://www.cdc.gov/mentalhealth/index.htm

52. Centers for Disease Control and Prevention. (2021, July 20). *Mental health*. https://www.cdc.gov/mental-health/?CDC_AAref_Val=https://www.cdc.gov/mentalhealth/index.htm

- Excessively sad feelings
- Confused thinking or problems concentrating and learning
- Extreme mood changes, including uncontrollable “highs” or feelings of euphoria
- Prolonged or strong feelings of irritability or anger
- Avoidance of friends and social activities
- Difficulties understanding or relating to other people
- Changes in sleeping habits or feeling tired and low energy
- Changes in eating habits, such as increased hunger or lack of appetite
- Changes in sex drive
- Disturbances in perceiving reality (e.g., delusions and hallucinations)
- Inability to perceive changes in one’s own feelings, behavior, or personality (i.e., lack of insight)
- Overuse of substances like alcohol or drugs
- Multiple physical ailments without obvious causes (such as headaches, stomachaches, or vague and ongoing “aches and pains”)
- Thoughts of suicide
- Inability to carry out daily activities or handle daily problems and stress
- An intense fear of weight gain or overly concerned with appearance

Mental health conditions are also present in children. Because children are still learning how to identify and talk about thoughts and emotions, their most obvious symptoms are behavioral. Behavioral symptoms in children can include the following⁵³:

- Changes in school performance
- Excessive worry or anxiety
- Hyperactive behavior
- Frequent nightmares
- Frequent disobedience or aggression

53. National Alliance on Mental Illness. (n.d.). *Warning signs and symptoms*.
<https://nami.org/About-Mental-Illness/Warning-Signs-and-Symptoms>

- Frequent temper tantrums

Nurses should recognize signs and symptoms of potentially undiagnosed mental health problems in all care settings and make appropriate referrals to mental health professionals and support organizations.

- ▶ [National Alliance on Mental Illness \(NAMI\)](#) provides advocacy, education, support, and public awareness so that all individuals and families affected by mental illness can build better lives. NAMI's strategic goals are for people to get help early, get the best possible care, and be diverted from justice system involvement.⁵⁴

NAMI offers these programs that promote improved care for individuals with mental illness and their loved ones:

- ▶ [Your Journey With Mental Illness](#) is a web page with several resources such as understanding your diagnosis, finding a health professional, understanding insurance, handling a crisis, and navigating finances and work.
- ▶ [NAMI Basics](#) is an educational program for parents, family members, and caregivers who provide care for youth (ages 22 and younger) who are experiencing mental health symptoms. The program covers these topics:
 - Impact mental health conditions can have on the entire family

54. National Alliance on Mental Health. (n.d.). *2020-2025 strategic plan*. <https://nami.org/NAMInet/Board-of-Directors/Governance-Documents/NAMIStrategicPlan2020>

- Different types of mental health care professionals and available treatment options and therapies
 - Overview of the public mental health care, school, and juvenile justice systems and resources to help navigate these systems
 - Child rights advocacy at school and in health care settings
 - Preparation and response to crisis situations (self-harm, suicide attempts, etc.)
 - Importance of self-care
- ▶ [NAMI Provider](#) introduces mental health professionals to the unique perspectives of people with mental health conditions and their families. It promotes empathy for their daily challenges and the importance of including them in all aspects of the treatment process.
 - ▶ [NAMI In Our Own Voice](#) is a program to promote a change in attitudes, assumptions, and ideas about people with mental health conditions. Presentations provide a personal perspective of mental health conditions, as leaders with lived experience talk openly about what it's like to have a mental health condition.

Homeless People

Homelessness can significantly affect an individual's health in three ways: health problems caused by homelessness, health problems that cause homelessness, and health conditions that are difficult to treat because of

homelessness. As a result, the average age of death among homeless people is the mid-50s.⁵⁵

Homeless people face multiple barriers to health care, including transportation, fragmentation of health care services, difficulty scheduling and keeping appointments, stigma of homelessness, lack of trust, social isolation, and significant basic physiological needs. Homeless people frequently have multiple needs resulting from exposure to violence or the elements, food insecurity, and untreated or undertreated physical and mental illnesses, resulting in frequent emergency department visits and hospitalizations.⁵⁶

Effective health care for the homeless population addresses social determinants of health, such as housing, income, food, and social supports. The Medical Home Model developed by the Veterans Health Administration is an example of a proactive, primary care-based, interdisciplinary team model based on client-centered, holistic care, and active communication and coordination among providers. This model is considered effective for clients with complex health care needs. See Figure 17.11⁵⁷ for an illustration of the

55. O'Toole, T. P., Johnson, E. E., Aiello, R., Kane, V., & Pape, L. (2016). Tailoring care to vulnerable populations by incorporating social determinants of health: The veterans health administration's "homeless patient aligned care team" program. *Preventing Chronic Disease*, 13:150567. <http://dx.doi.org/10.5888/pcd13.150567>
56. O'Toole, T. P., Johnson, E. E., Aiello, R., Kane, V., & Pape, L. (2016). Tailoring care to vulnerable populations by incorporating social determinants of health: The veterans health administration's "homeless patient aligned care team" program. *Preventing Chronic Disease*, 13:150567. <http://dx.doi.org/10.5888/pcd13.150567>
57. This image is derived from O'Toole TP, Johnson EE, Aiello R, Kane V, Pape L. (2016). Tailoring care to vulnerable populations by incorporating social

Medical Home Model. As homeless veterans stabilize clinically and socially, as evidenced by their moving into permanent housing and demonstrating appropriate self-care and health-seeking behaviors, they are transitioned to traditional care settings to continue their care.⁵⁸

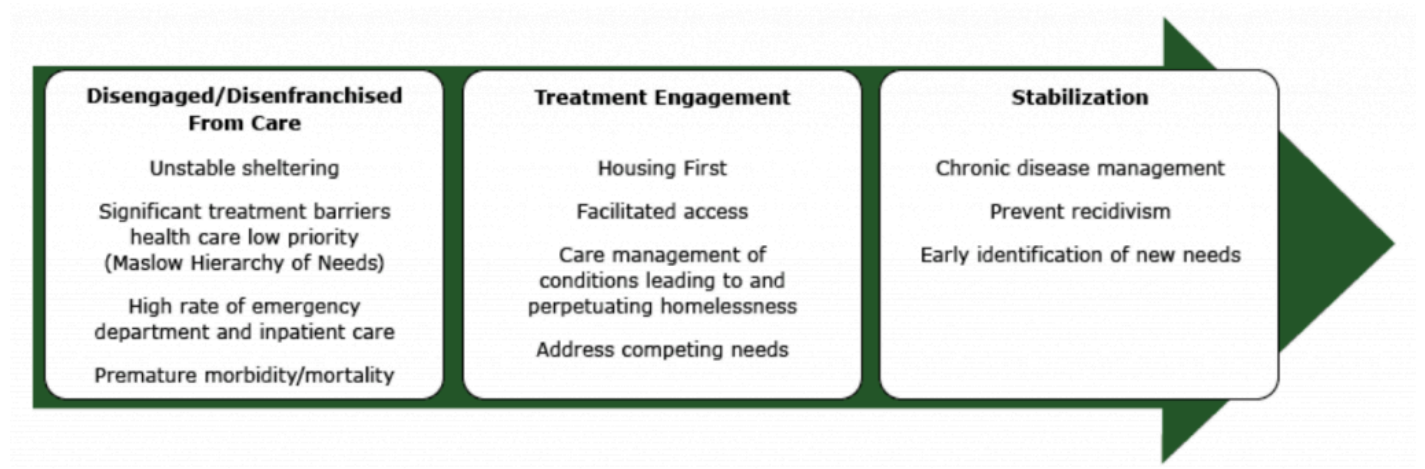


Figure 17.11 Medical Home Model

Core elements of the Medical Home Model distinguish it from traditional primary care with the following characteristics⁵⁹:

determinants of health: The veterans health administration's "homeless patient aligned care team" program. *Preventing Chronic Disease* 13:150567. <http://dx.doi.org/10.5888/pcd13.150567>

58. O'Toole, T. P., Johnson, E. E., Aiello, R., Kane, V., & Pape, L. (2016). Tailoring care to vulnerable populations by incorporating social determinants of health: The veterans health administration's "homeless patient aligned care team" program. *Preventing Chronic Disease*, 13:150567. <http://dx.doi.org/10.5888/pcd13.150567>

59. O'Toole, T. P., Johnson, E. E., Aiello, R., Kane, V., & Pape, L. (2016). Tailoring care to vulnerable populations by incorporating social determinants of

- Low-threshold access to care
 - Open access with walk-in capacity and flexible scheduling (i.e., clients do not need an appointment to be seen by their care team)
 - Clinical outreach to homeless people on streets, in shelters, and in community locations such as soup kitchens
- Integrated services
 - Mental health services and primary care services are located close to each other, and providers from both services are involved in clients' health care plan
 - Sustenance needs (e.g., food or food vouchers, hygiene kits, clothes, bus passes, other transportation assistance) are available at the same location
- Intensive health care management integrated with community agencies with an emphasis on ongoing, continuous care
- Ongoing staff training focused on development of homeless care skills

Research indicated the Medical Home Model reduced emergency

health: The veterans health administration's "homeless patient aligned care team" program. *Preventing Chronic Disease*, 13:150567.

<http://dx.doi.org/10.5888/pcd13.150567>

department visits and hospitalizations of the homeless population by integrating supports that addressed social determinants of health into a clinical care model.⁶⁰

⁶⁰. O'Toole, T. P., Johnson, E. E., Aiello, R., Kane, V., & Pape, L. (2016). Tailoring care to vulnerable populations by incorporating social determinants of health: The veterans health administration's "homeless patient aligned care team" program. *Preventing Chronic Disease*, 13:150567. <http://dx.doi.org/10.5888/pcd13.150567>

17.3 Spotlight Application

This section will apply the tools from the “[Community Assessment](#)” chapter to providing care for victims of human trafficking as an example of a nurse generalist caring for a member of a vulnerable population. See Figure 17.12¹ regarding human trafficking initiatives.



Figure 17.12 Human Trafficking Initiatives

After hearing about a sexual trafficking arrest at a local hotel in the news, a nurse who works in the emergency department reads more information on the [National Human Trafficking Hotline](#). Because the community is located near a major national interstate, the nurse realizes there are likely many unidentified victims of human trafficking passing through the community.

1. "[OAG-2020-Sex-Trafficking-Poster-English](#)" by [Office of Attorney General for the District of Columbia](#) is in the [Public Domain](#).

The nurse develops a goal to improve the identification and support of individuals experiencing human trafficking in the community.

The nurse begins a community health needs assessment by reading statistics on the ► [National Human Trafficking Hotline](#), as well as additional information in the ► [Adult Human Trafficking Screening Tool and Guide](#) PDF by the U.S. Department of Health and Human Services' Administration for Children and Families. Based on this research, the nurse keeps the following tips in mind when conducting an assessment with a potential victim of trafficking^{2,3},

- **Lack of self-identification.** Many victims do not self-identify as human trafficking victims due to lack of knowledge about the crime, as well as power and control dynamics involved in trafficking situations.
- **Being conscious of verbal and nonverbal messages.** When speaking with a potential victim of trafficking, the nurse plans on adopting open, nonthreatening body positioning; maintaining a calm tone of voice; displaying a warm, natural facial expression; using active listening skills; and mirroring the language the potential victim uses. For example, if the potential victim refers to her controller as her boyfriend, referring to that person as a “pimp” or a “sex trafficker” can negatively impact a therapeutic nurse-client relationship.
- **Being aware of power dynamics.** If a third party accompanies or interprets for the potential victim, the nurse plans on trying to speak to the potential victim alone or in a secure area with an official interpreter.
- **Being aware of canned stories.** Scripted stories are common, and the true

2. National Human Trafficking Resource Center. (2011). *Human trafficking assessment for domestic violence & sexual assault programs*. <https://humantraffickinghotline.org/states>

3. Macias-Konstantopoulos, W., & Owens, J. (2018). *Adult human trafficking screening tool and guide* [PDF]. Administration for Children & Families and National Human Trafficking. https://www.acf.hhs.gov/sites/default/files/documents/otip/adult_human_trafficking_screening_tool_and_guide.pdf

story may not emerge until trust has been built with the potential victim.

- **Meeting the person's physical needs by offering a snack or beverage.** Most individuals experiencing human trafficking have been deprived of basic necessities, such as food, fluids, sleep, and urgent medical needs. Hunger is a very common problem for individuals who have been trafficked; a person who is hungry will have difficulty focusing and may be irritable.
- **Never allow confidential data to leave the office.** Ensure secure mechanisms to maintain privacy of client data (e.g., use effective passwords and/or locked file cabinets).
- **Being empathetic.** The decision to disclose trafficking can be mentally challenging, emotionally draining, and potentially physically unsafe for the victim. If the victim does not feel prepared to disclose during the immediate clinical visit, disclosure may occur at a future visit.⁴

Assessment

The nurse is aware of the warning signs an individual who is a victim of human trafficking or sexual violence may exhibit⁵:

- Shares a scripted or inconsistent history
- Is unwilling or hesitant to answer questions about an injury or illness
- Is accompanied by an individual who does not let the client speak for themselves, refuses to let the client have privacy, or who interprets for them
- Shares information about controlling or dominating relationships

4. Tracy, E. E., & Macias-Konstantopoulos, W. (2021). Human trafficking: Identification and evaluation in the health care setting. *UpToDate*. Retrieved March 16, 2022, from www.update.com

5. Tracy, E. E., & Macias-Konstantopoulos, W. (2021). Human trafficking: Identification and evaluation in the health care setting. *UpToDate*. Retrieved March 16, 2022, from www.update.com

- Demonstrates fearful or nervous behavior or avoids eye contact
- Is resistant to accept assistance or demonstrates hostile behavior
- Is unable to provide their address
- Is not aware of their location, the current date, or time
- Is not in possession of their identification documents
- Is not in control of his or her own money
- Is not being paid or wages are withheld

Sex trafficking victims may exhibit the following⁶:

- Client is under the age of 18 and is involved in the commercial sex industry
- Has tattoos or other forms of branding, such as tattoos that say “Daddy,” “Property of...,” “For sale,” etc.
- Reports an unusually high number of sexual partners
- Does not have appropriate clothing for the weather or venue
- Uses language common in the commercial sex industry
- Experiences multiple sexually transmitted infections, pregnancies, miscarriages, or terminations

If concerning assessment findings are noted, the nurse plans on using a screening tool found in the ► [Adult Human Trafficking Screening Tool and Guide PDF](#). Before beginning any conversation with the client, the nurse plans to assess for potential safety risks that may result from asking the client sensitive questions and to ensure privacy. The nurse also plans on being transparent about the limits of confidentiality regarding mandated reporting.⁷

6. Tracy, E. E., & Macias-Konstantopoulos, W. (2021). Human trafficking: Identification and evaluation in the health care setting. *UpToDate*. Retrieved March 16, 2022, from www.update.com

7. Tracy, E. E., & Macias-Konstantopoulos, W. (2021). Human trafficking:

Diagnosis

Several nursing diagnoses may apply to individuals experiencing human trafficking or sexual violence. Examples of diagnoses include the following⁸:

- *Post-Trauma Syndrome* related to insufficient social support
- *Powerlessness* related to insufficient sense of control
- *Chronic Low Self-Esteem* related to inadequate belonging
- *Risk for Impaired Emancipated Decision-Making* as manifested by insufficient privacy to openly discuss health care options

Outcome Identification

The overall goal of the nurse is to identify and support victims of human trafficking or sexual violence. Individual SMART goals can be established for clients based on their circumstances. Some examples of SMART outcomes are as follows:

- The client will remain safe from injury and death.
- The client will verbalize local resources and support before the end of the visit.
- The client will acknowledge the traumatic experience and begin to work through the trauma by verbalizing feelings of fear, anger, anxiety, or

Identification and evaluation in the health care setting. *UpToDate*. Retrieved March 16, 2022, from www.update.com

8. Ackley, B., Ladwig, G., Makic, M. B., Martinez-Kratz, M., & Zanoliti, M. (2020). *Nursing diagnosis handbook: An evidence-based guide to planning care* (12th ed.). Elsevier.

helplessness during the visit.

Planning Interventions

The nurse prepares to respond quickly based on the client's circumstances by doing the following:

- Knowing how to contact law enforcement if the client or staff are in immediate danger.
- Being prepared to complete mandatory reporting requirements for minors and other circumstances according to state law.
- Creating a list of local services and resources to provide to human trafficking victims.

The nurse plans on sharing these resources regarding human trafficking with local community representatives associated with urgent care centers, clinics, primary care providers, and emergency departments.

Implementation

The nurse implements interventions with individuals seeking care based on assessment findings. Individualized interventions may include these steps:

- Contact law enforcement if the client or staff are in immediate danger.
- Create a safety plan by identifying the current level of risk and safety concerns. Outline concrete options for responding when the individual's safety is threatened.
- Refer the victim to local services and resources, such as food, shelter, and legal services.
- Share referral options. For assistance with finding referrals or other resources, contact the National Human Trafficking Hotline at 1-888-373-7888.
- Be prepared to respond to a potential trauma reaction. Encourage relaxation breathing and grounding techniques for immediate de-escalation. (Review crisis intervention in the "[Stress, Coping, and Crisis Intervention](#)" chapter and grounding techniques in the "[Anxiety](#)")

[Disorders](#)” chapter.)

- Perform mandatory reporting for minors and other circumstances according to state law. Read more about mandatory reporting in the box below.
- Report the case confidentially to appropriate authorities trained on human trafficking.
- Document assessment findings and referrals. Maintain client privacy and ensure the documentation is secure electronically or on paper.

Mandatory Reporting

Mandatory reporting is required for minors. Read more about mandatory reporting in the “[Legal and Ethical Considerations in Mental Health Care](#)” chapter. If reporting human trafficking of adults is not a component of your state’s mandatory reporting statutes, certain circumstances may be considered reportable. Some of these “reportable” circumstances may include domestic violence, injuries caused in violation of criminal law, or injuries caused by a deadly weapon (e.g., firearm, knife, or machete). Some professionals hesitate to report potential victims of trafficking due to fears of violating the rules of the Health Insurance Portability and Accountability Act (HIPAA). HIPAA was written to protect client confidentiality but was not designed to prevent the reporting of trauma and crimes. If you’re unsure about whether HIPAA permits the reporting of client information in a specific situation, human trafficking can still be reported without divulging individually identifiable client health

information. For example, you could report the gender, age of client, and type of trafficking.⁹

Evaluation

The nurse plans on evaluating the success of achieving the overall goal to improve the identification and support of individuals experiencing human trafficking in the community in a variety of ways:

- Reviewing statistics reported by local law enforcement agencies regarding human trafficking cases.
- Reviewing statistics reported by the ► [National Human Trafficking Hotline](#).
- Informally interviewing local community representatives associated with urgent care centers, clinics, primary care providers, and emergency departments regarding human trafficking cases.

9. Macias-Konstantopoulos, W., & Owens, J. (2018). Adult human trafficking screening tool and guide. *Administration for Children & Families and National Human Trafficking* [PDF]. https://www.acf.hhs.gov/sites/default/files/documents/otip/adult_human_trafficking_screening_tool_and_guide.pdf

17.4 Learning Activities



An interactive H5P element has been excluded from this version of the text. You can view it online here:

<https://wtcs.pressbooks.pub/nursingmhcc/?p=806#h5p-56>

1



An interactive H5P element has been excluded from this version of the text. You can view it online here:

<https://wtcs.pressbooks.pub/nursingmhcc/?p=806#h5p-58>

2



1. “Vulnerable Populations Glossary Cards” by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)

2. “Vulnerable Populations Question Set” by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)

- ▶ Test your clinical judgment with an NCLEX Next Generation-style case study: [Chapter 17, Case Study 1](#)³

3. “Vulnerable Populations Next Gen Case Study” by Kellea Ewen is licensed under [CC BY-NC 4.0](#)

XVII Glossary

Health disparities: Health differences that are linked with social, economic, and/or environmental disadvantages. Health disparities adversely affect groups of people who often experience greater obstacles to health based on individual characteristics, such as socioeconomic status, age, gender, culture, religion, mental illness, disability, sexual orientation, or gender identity.

Health equity: The attainment of the highest level of health for all people.

Human trafficking victims: Individuals forced to work or provide commercial sex against their will in legal business settings and underground markets.

Migrant worker: A person who moves within their home country or outside of it to pursue work. Migrant workers usually do not intend to stay permanently in the country or region in which they work.

Telehealth: The use of digital technologies to deliver medical care, health education, and public health services by connecting multiple users in separate locations.

Vulnerable population: A group of individuals who are at increased risk for health problems and health disparities.

CHAPTER 18 ENVIRONMENTAL HEALTH AND EMERGENCY PREPAREDNESS

Learning Objectives

- Analyze the nursing role in emergency preparedness planning within the community
explain the nurse role as a collaborative advocate for the health needs of the community
- Describe the nurse's role in promoting environmental health
- Apply principles of triage
- Outline tips for preventing and managing stress for disaster responders

Since the early years of the profession, nursing leaders such as Florence Nightingale and Lillian Wald have recognized the role of nurses in controlling the influence of environmental factors on health. Nurses have long appreciated that a healthy environment impacts the physical and mental health of individuals, families, communities, and populations.¹

At some point during their career, nearly every nurse finds themselves caring for individuals affected by exposure to an environmental hazard or disaster. Disasters have environmental, physical, and psychological effects on individuals and communities. The increasing impacts of natural, man-made, and infectious disease disasters have changed health care and nursing

1. American Nurses Association. (2007). *ANA's principles of environmental health for nursing practice with implementation strategies*. Nursesbooks.org. <https://www.nursingworld.org/practice-policy/work-environment/health-safety/environmental-health/>

perspectives around the world. Nurses are on the front lines in supporting individuals and communities affected by disasters. This chapter will review nurses' roles in promoting environmental health and treating individuals exposed to environmental hazards, as well as participating in emergency preparedness and disaster response and recovery.

Category	Environmental Hazards
Housing	Building Contaminants: Radon, asbestos, carbon monoxide, and lead Personal Chemicals: Nail polish remover, spray deodorant, and rubbing alcohol Household Chemicals: Kerosene, coal or wood-burning stoves, burning pine cones or wax candles, burning incense, chlorinated water in swimming pools, cleaning products, household detergents, plastic cement, acrylic paints, furniture wax, rubber-based paints, gasoline, white-out solvents, and pesticides (used in gardening chemicals and lawn care) Electromagnetic Pollution: Electric blankets, electrically heated water beds, fluorescent lighting, cathode ray tubes (computer terminals), cellphones, tablets, microwave ovens, television sets, radio or TV transmission towers, short-wave radio transmitters, and high-voltage electrical power lines Natural Contaminants: Mold and pollen Human Contaminants: Second-hand smoke

Occupational	Medical Chemicals: Injectable phenol (found in allergy shots) and silver amalgam (found in some dental fillings) Occupational Chemicals: Radioactivity from direct radiation or decay from nuclear waste Construction Materials & Industry: Urea-formaldehyde foam insulation, asbestos insulation, fiberglass & particleboard, treated lumber, and silica air pollution Noise Pollution: Traffic, loud music, workplace equipment noise, and airports Ergonomics: Physical injuries due to positioning or lack of physical assistance Communicable Infectious Disease: Exposure to infections despite transmission precautions (i.e., airborne, droplet, or contact precautions). Read more about the chain of infection and transmission precautions in the “Infection” chapter of <i>Open RN Nursing Fundamentals</i>.
Atmosphere	Air pollution Greenhouse Gasses: Carbon dioxide, methane, nitrous oxide, and fluorinated gasses Ultraviolet Radiation
Waterborne Illness (Recreational or drinking water contaminated by disease-causing contaminants, microbes or pathogens)	Chemical and Metal Contaminants: Chlorine, fluorine, mercury, lead, and nitrates Common Microbes: Cryptosporidiosis, cyclosporiasis, Escherichia, giardiasis, legionellosis, norovirus, shigellosis, blue-green algae, schistosome parasites (swimmer’s itch), pseudomonas (hot tub rash), and cholera. Read more about waterborne illness at the Wisconsin Department of Health or the Minnesota Department of Health. *Report waterborne illness to the state Department of Health.

Foodborne Illness (Consuming foods or beverages contaminated with bacteria, viruses, parasites, toxins, or chemicals)	Common Pathogens: Clostridium botulinum, listeria, campylobacter, norovirus, clostridium perfringens, cryptosporidiosis, cyclosporiasis, Escherichia, giardiasis, salmonellosis, shigellosis, toxoplasmosis, yersiniosis, and hepatitis A Read more about foodborne illness at the Wisconsin Department of Health or Minnesota Department of Health . *Report foodborne illness to the state Department of Health.

Recognizing environmental hazards can help community health nurses provide information to community members and implement prevention strategies that promote positive outcomes. See Figure 18.1² for an example of prevention strategies related to the environmental hazard of lead poisoning.

2. “preventable.jpg” by unknown author for [National Center for Environmental Health, Division of Environmental Health Science and Practice](#) is in the [Public Domain](#).



Figure 18.1 Lead Poisoning

The American Nurses Association (ANA) established an *Environmental Health* standard defined as, “The registered nurse practices in a manner that advances environmental safety and health.”³ Review the competencies for this standard in the following box.

3. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

ANA's Environmental Health Competencies⁴

The registered nurse:

- Creates a safe and healthy workplace and professional practice environment
- Fosters a professional environment that does not tolerate abusive, destructive, and oppressive behaviors
- Promotes evidence-based practices to create a psychologically and physically safe environment
- Assesses the environment to identify and address the impact of social determinants of health on risk factors
- Reduces environmental health risks to self, colleagues, health care consumers, and the world
- Integrates environmental health concepts in practice
- Communicates information about environmental health risks and exposure risk strategies
- Advocates for the implementation of environmental health principles in communities in which they work and live
- Incorporates technologies to promote safe practice environments
- Uses products or treatments consistent with evidence-based practice to reduce environmental threats and hazards
- Examines how the health care consumer's biography affects their biology, resultant health issues, and the ecosystem

4. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

- Analyzes the impacts of social, political, and economic influences on the human health experience and global environment
- Advances environmental concerns and complaints through advocacy and appropriate reporting mechanisms
- Promotes sustainable global environmental health policies and conditions that focus on prevention of hazards to people and the natural environment

Caring for individuals exposed to environmental hazards will be discussed in the following “Emergency Preparedness, Response, and Recovery” section.

Read more information about promoting environmental health and safety in nursing in the following box.

- ▶ Read a free e-book titled [*Environmental Health in Nursing*](#) published by the Alliance of Nurses for Healthy Environments (ANHE).
- ▶ Review the “[Environmental Safety](#)” section of the “Safety” chapter in *Open RN Nursing Fundamentals*.

18.3 Emergency Preparedness, Response, and Recovery

A **disaster** is defined as a serious disruption of the functioning of a community or a society at any scale due to hazardous events interacting with conditions of exposure, vulnerability, and capacity that lead to human, material, economic, and environmental losses and impacts.¹ Every community must prepare to respond to disasters that include natural events (e.g., tornadoes, hurricanes, floods, wildfires, earthquakes, or disease outbreaks), man-made events (e.g., harmful chemical spills, mass shootings, or terrorist attacks), or infectious disease outbreaks. See Figure 18.2² for an image of the effects of the natural disaster Hurricane Katrina.



Figure 18.2 Effects of Hurricane Katrina

Emergency preparedness is the planning process focused on avoiding or reducing the risks and hazards resulting from a disaster to optimize

1. National Academies of Sciences, Engineering, and Medicine. (2021). *The future of nursing 2020-2030: Charting a path to achieve health equity*. National Academies Press. <https://doi.org/10.17226/25982>
2. “LA_1603_9thDistDam121.jpg” by Booher, Andrea, Photographer is in the [Public Domain](#).

population health and safety. **Disaster management** refers to the integration of emergency response plans throughout the life cycle of a disaster event. Because disasters cause physical and psychological effects in a community, emergency preparedness and disaster management emphasize collaboration and cooperative aid among health care institutions and community agencies to ensure a coordinated and effective response.³

- ▶ Read the American Nurses Association resource regarding [Disaster Preparedness](#).

Emergency preparedness and disaster management are based on four key concepts: preparedness, mitigation, response, and recovery. This process guides decision-making when an emergency or disaster occurs in a community.⁴ After the disaster event has concluded, evaluation of the effectiveness of the response occurs as part of planning emergency preparedness. See Figure 18.3⁵ for a diagram that illustrates this theoretical framework for emergency preparedness. Each of these concepts is further discussed in the following subsections.

3. Savage, C. L. (2020). *Public/community health and nursing practice: Caring for populations* (2nd ed.). FA Davis.
4. Emergency Management Institute. (2013). *ISS-111.A: Livestock in disasters*. Federal Emergency Management Agency. <https://training.fema.gov/is/courseoverview.aspx?code=iss-111.a&lang=en>
5. “Environmental Health and Emergency Preparedness” by Dawn Barone for [Open RN](#) is licensed under [CC BY 4.0](#)

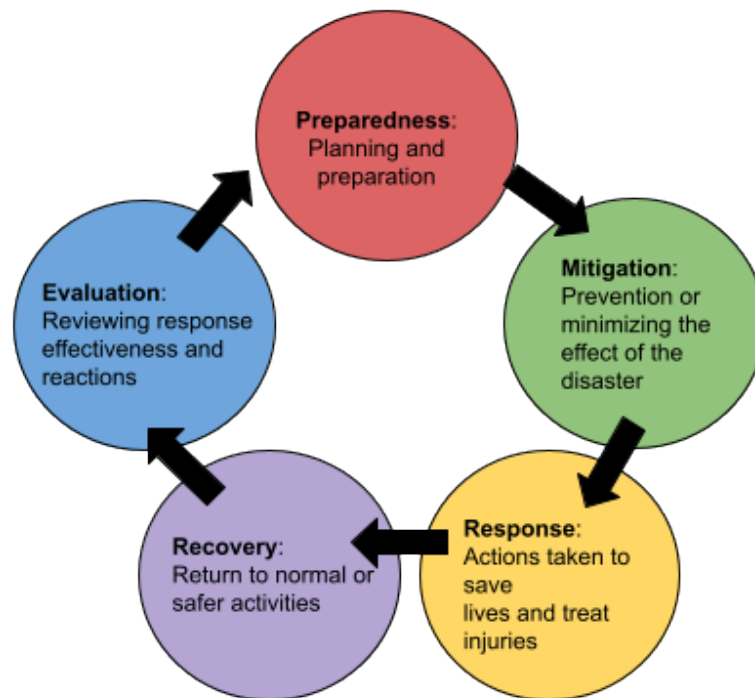


Figure 18.3 Key Concepts in Emergency Preparedness and Response

Preparedness

Preparedness includes planning, training personnel, and providing educational activities regarding potential disastrous events. Planning includes evaluating environmental risks and social vulnerabilities of a community. Environmental risk refers to the probability and consequences of an unwanted accident in the environment in which community members live, work, or play. Risk assessment also includes assessing social vulnerabilities that affect community resilience.⁶

6. Flanagan, B. E., Hallisey, E. J., Adams, E., & Lavery, A. (2018). Measuring community vulnerability to natural and anthropogenic hazards: The Centers

Social vulnerability refers to the characteristics of a person or a community that affect their capacity to anticipate, confront, repair, and recover from the effects of a disaster.⁷ Populations living in a disaster-stricken area are not affected equally. Many factors can weaken community members' ability to respond to disasters, including poverty, lack of access to transportation, and crowded housing. Evidence indicates that those living in poverty are more vulnerable at all stages of a catastrophic event, as are racial and ethnic minorities, children, elderly, and disabled people.⁸ Socially vulnerable communities are more likely to experience higher rates of mortality, morbidity, and property destruction and are less likely to fully recover in the wake of a disaster compared to communities that are less socially vulnerable. Community health nurses must plan emergency responses to disasters that address these social vulnerabilities to decrease human suffering and financial loss.

The Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) created a Social Vulnerability Index database and mapping tool designed to assist state, local, and tribal

for Disease Control and Prevention's social vulnerability index. *Journal of Environmental Health*, 80(10). 34–36. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7179070/>

7. Flanagan, B. E., Hallisey, E. J., Adams, E., & Lavery, A. (2018). Measuring community vulnerability to natural and anthropogenic hazards: The Centers for Disease Control and Prevention's social vulnerability index. *Journal of Environmental Health*, 80(10). 34–36. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7179070/>
8. Flanagan, B. E., Hallisey, E. J., Adams, E., & Lavery, A. (2018). Measuring community vulnerability to natural and anthropogenic hazards: The Centers for Disease Control and Prevention's social vulnerability index. *Journal of Environmental Health*, 80(10). 34–36. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7179070/>

disaster management officials in identifying the locations of their most socially vulnerable populations. Geographic patterns of social vulnerabilities can be used in all phases of emergency preparedness and disaster management. See Figure 18.4⁹ for an image of social vulnerability mapping.

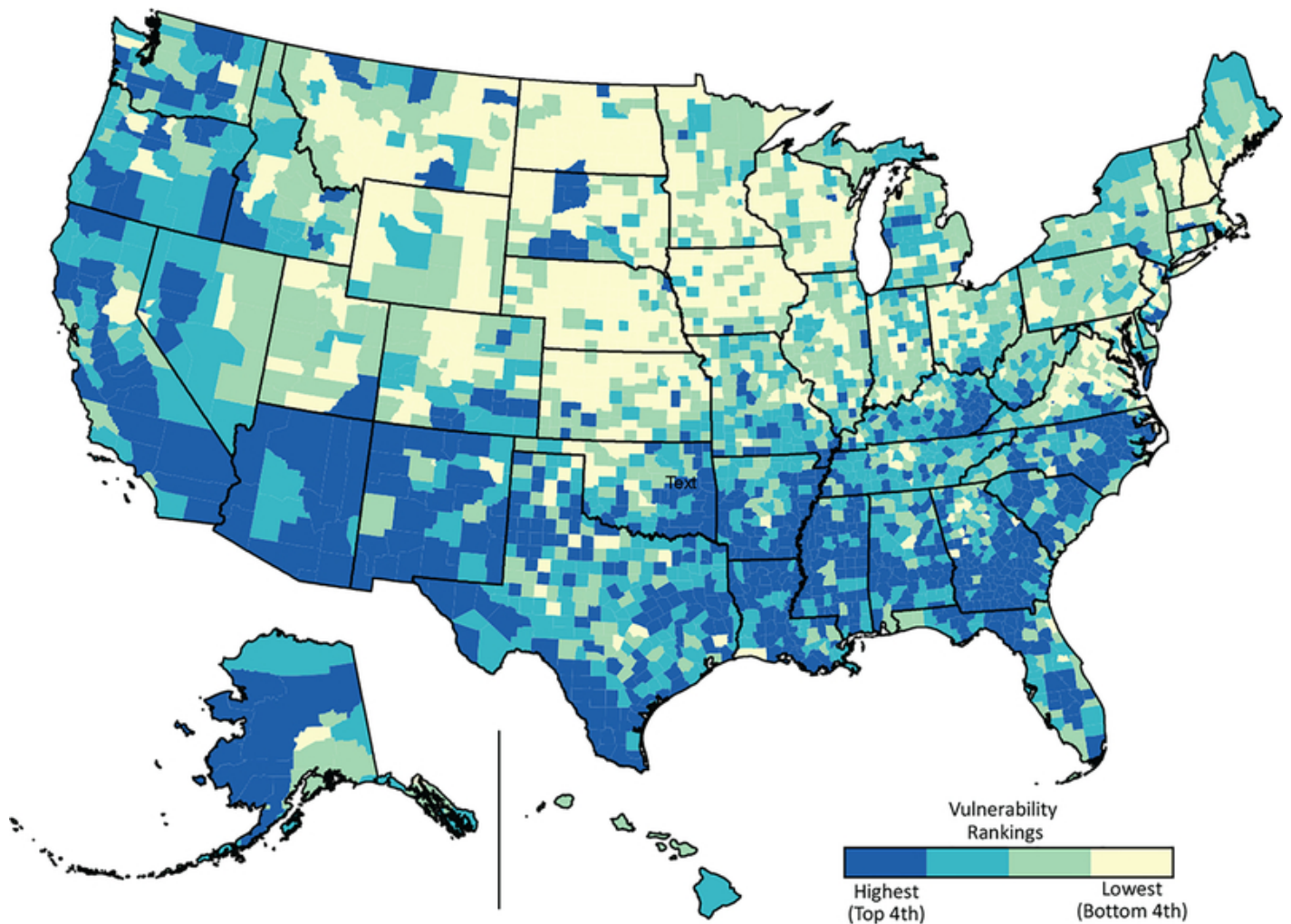


Figure 18.4 Social Vulnerability Mapping Waiting on permission

9. This image is derivative of Flanagan, B. E., Hallisey, E. J., Adams, E., & Lavery, A. (2018). Measuring community vulnerability to natural and anthropogenic hazards: The Centers for Disease Control and Prevention's social vulnerability index. *Journal of Environmental Health*, 80(10), 34–36. Access the report at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7179070/>

► View the [CDC/ATSDR Social Vulnerability Index Interactive Map](#).

Mitigation

Mitigation refers to actions taken to prevent or reduce the cause, impact, and consequences of disasters. Health care institutions and community health agencies plan using the three C's to mitigate the effects of a disaster:

- **Communication:** An emergency communication plan identifies tools, resources, teams, and strategies to ensure effective actions during emergencies.
- **Coordination:** Coordination plays a crucial role in efficiency and effectiveness of disaster management by providing a big picture of an emergency and reducing uncertainty levels among responders.
- **Collaboration:** Collaboration allows responders to act together smoothly and helps reduce impact of the disaster.

Response

The **response** phase occurs in the immediate aftermath of a disaster. When a disaster occurs, actions are taken to save lives, treat injuries, and minimize the effect of the disaster. Immediate needs are addressed, such as medical treatment, shelter, food, and water, as well as psychological support of survivors. Personal safety and well-being in an emergency and the duration of the response phase depend on the level of a community's preparedness. Examples of response activities include implementing disaster response plans, conducting search and rescue missions, and taking actions to protect oneself, family members, pets, and other community members.¹⁰

10. Emergency Management Institute. (2013). *ISS-111.A: Livestock in disasters*.

While the immediate actions of responding to a disaster are treating physical injuries, psychological effects must be addressed as well. To minimize psychological effects, nurses and first responders can provide support to victims of the disaster by following these tips from the Substance Abuse and Mental Health Services Administration (SAMHSA)¹¹:

- **Promote safety:** Ensure basic needs are met and provide simple instructions about how to receive these basic needs.
- **Promote calm:** Listen to people express their feelings and provide empathy and compassion even if they are angry, upset, or acting out. Offer objective information about the situation and efforts being made to help those affected by the disaster.
- **Promote connectedness:** Help people connect with friends, family members, and other loved ones. Keep families and family units together as best as possible, especially by keeping children with those whom they feel safe.
- **Promote self-efficacy:** Give suggestions about how people can help themselves and guide them toward the resources available. Encourage families and individuals to help meet their own needs.
- **Promote help and hope:** Know what services are available and direct people to those services and continue to update people about what is being done. When people are worried or scared, remind them that help is on the way.

Federal Emergency Management Agency. <https://training.fema.gov/is/courseoverview.aspx?code=is-111.a&lang=en>

11. Substance Abuse and Mental Health Services Administration. (2005). *Psychological first aid for first responders*. [Handout]. U.S. Department of Health & Human Services. <https://store.samhsa.gov/product/Psychological-First-Aid-for-First-Responders/NMH05-0210>

Disaster Response Protocols

When thinking about responding to a disaster, first responders and emergency personnel come to mind such as law enforcement, fire departments, and emergency medical technicians (EMTs). However, nurses are also called upon to assist in emergencies or disasters and must be competent in responding. Nurses may be involved in triaging individuals for treatment.

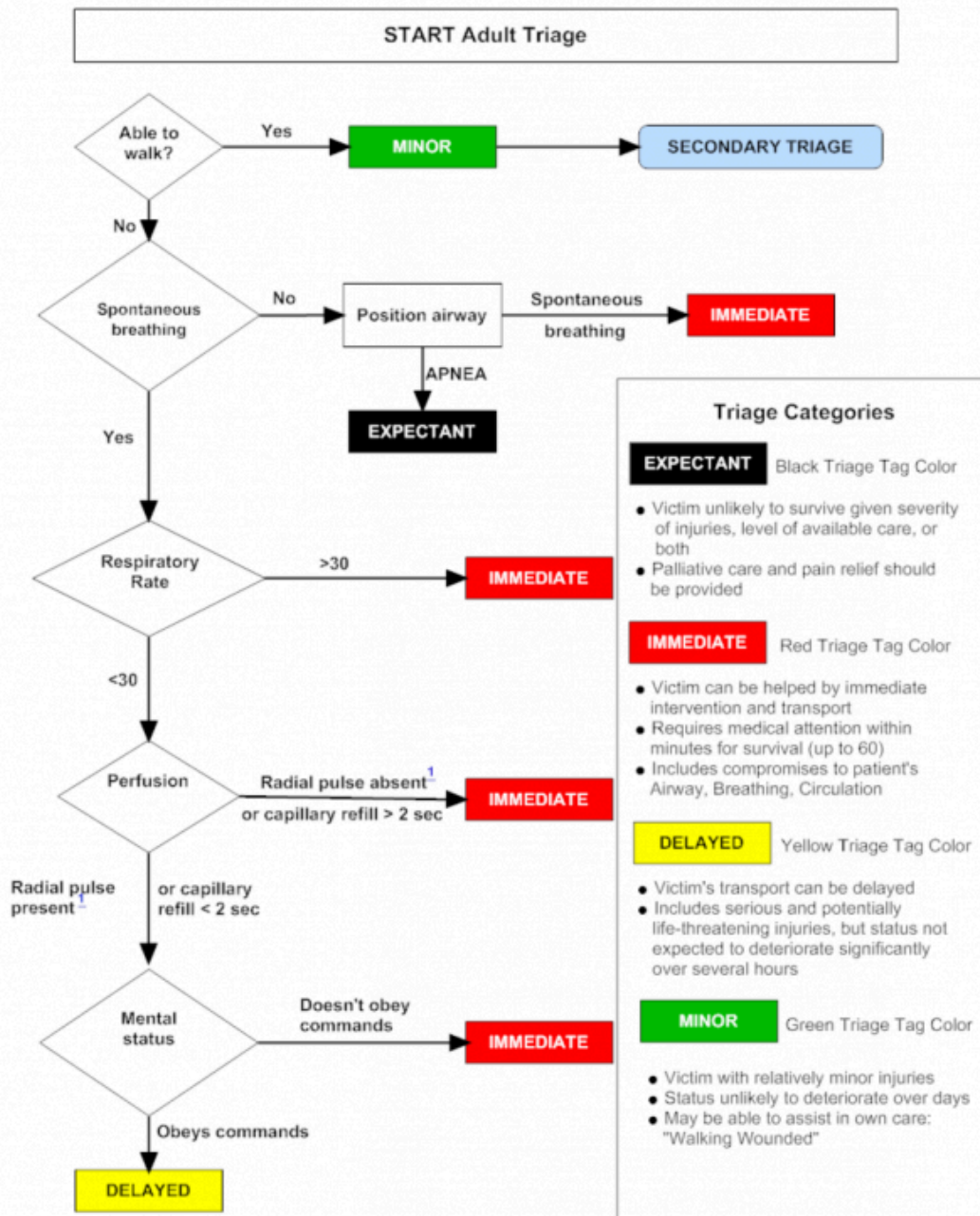
To respond effectively when a disaster occurs, emergency responders perform **triage** by prioritizing treatment for individuals affected by the disaster or emergency. **Field triage** sorts victims affected by the event and ranks victims based on the severity of their symptoms. **Disaster triage** determines the severity of injuries suffered by victims and then systematically distributes them to local health care facilities based on their severity.

Simple Triage and Rapid Treatment (START) is an example of a triage system established by the U.S. Department of Health and Human Services that prioritizes treatment of victims by using standard colors indicating the severity of symptoms and prognosis. See Figure 18.5¹² for the START algorithm. The following colors indicate severity of injury and prognosis:

- **RED:** Emergent needs
 - Life-threatening needs, such as alterations in airway, breathing, and circulation; impairment in neurological systems; or severe, life-threatening injuries.
 - They may have less than 60 minutes to survive.
 - These patients will be seen first or immediately.
- **YELLOW:** Urgent, but delayed needs

12. "[StartAdultTriageAlgorithm.png](#)" by unknown author at [CHEMM](#) is in the [Public Domain](#).

- Life-threatening needs; status is not anticipated to change quickly or significantly in the next hours, so transport can be delayed.
- **GREEN:** Non-urgent needs, often referred to as the “walking wounded”
 - Minor injuries; status is not likely to deteriorate over the next several days.
 - Many individuals can assist with obtaining their own care.
- **BLACK:** The person has died or is expected to die soon
 - This person is unlikely to survive given the severity of their injuries, level of available care, or both.
 - Palliative care and pain relief should be provided.



Adopted from <http://www.start-triage.com>

Figure 18.5 START Adult Triage

Providing Care for Those Exposed to Environmental Hazards

Nurses may be involved in caring for clients who have been exposed to chemicals or other environmental hazards. See Table 18.3 for assessment findings and interventions for a variety of exposures. **Chelation therapy** is a treatment indicated for heavy metal poisoning such as mercury, arsenic, and lead. Chelators are medications that bind to the metals in the bloodstream to increase urinary excretion of the substance.

Some chemical exposures require decontamination to treat the individual, as well as to protect others around them, including first responders, nurses, and other clients. **Decontamination** is any process that removes or neutralizes a chemical hazard on or in the client to prevent or mitigate adverse health effects to the client; protect emergency first responders, health care facility first receivers, and other clients from secondary contamination; and reduce the potential for secondary contamination of response and health care infrastructure. For example, if a farmer enters a rural hospital's emergency department after chemical exposure to an insecticide spray, decontamination may be required. See Figure 18.6¹³ for an image of decontamination.

13. "[decontamination26.jpg](#)" by Benjamin Crossley CDP/[FEMA](#) is in the [Public Domain](#).



Figure 18.6 Decontamination

The decision to decontaminate an individual should take into account a combination of these key indicators¹⁴ :

- Signs and symptoms of exposure displayed by the client
- Visible evidence of contamination on the client's skin or clothing
- Proximity of the client to the location of the chemical release
- Contamination detected on the client using appropriate detection technology
- The chemical and its properties
- Request by the client for decontamination, even if contamination is

14. U.S. Department of Homeland Security, & U.S. Department of Health & Human Services. (2014). *Patient decontamination in a mass chemical exposure incident: National planning guidance for communities* [PDF]. <http://www.phe.gov/Preparedness/responders/Documents/patient-decont-natl-plng-guide.pdf>

unlikely

Table 18.3 Assessment Findings and Interventions for Exposure to Various Environmental Hazards

Chemical or Hazard	Assessment Findings	Interventions
Carbon Monoxide (CO) Poisoning (Auto exhaust and improperly vented or malfunctioning furnaces or fuel-burning devices)¹⁵	Primarily decreased mental status from confusion to coma May have cherry-red appearance of the lips and skin *Note: Pulse oximetry does not reflect accurate oxygenation levels because CO binds to hemoglobin.	• Remove from source of exposure • Provide fresh air • Administer high-flow oxygen by face mask; may require intubation and mechanical ventilation • Obtain arterial blood gas (ABG) sample of carboxyhemoglobin • Administer hyperbaric oxygen, if necessary
Lead Poisoning (Lead-contaminated paint dust, water, or food and bullets in wild game)^{16, 17}	Abdominal pain, constipation, fatigue, joint pain, muscle pain, headache, anemia, memory deficits, psychiatric symptoms, elevated blood pressure, decreased kidney function, decreased sperm count, increased mortality *Note: Some symptoms may be irreversible.	• Remove source of exposure • Monitor blood lead level (toxic effects occur if > 10 mcg) • Monitor hemoglobin and hematocrit for anemia • Monitor urinary output • Administer chelation therapy with ethylenediaminetetraacetic acid (EDTA) • Educate about lead-related health risks and removal of lead-based paint and other sources of exposure using safe OSHA practices

15. Clardy, P. F., & Manaker, S. (2021, June 17). Carbon monoxide poisoning. *UpToDate*. Accessed April 3, 2022, from www.update.com
16. World Health Organization. (2021, October 11). *Lead poisoning*. <https://www.who.int/news-room/fact-sheets/detail/lead-poisoning-and-health>
17. Goldman, R. H., & Hu, H. (2021, November 4). Lead exposure and poisoning in adults. *UpToDate*. Accessed April 3, 2022, from www.update.com

Formaldehyde Poisoning (Construction and agriculture products and disinfectants)¹⁸	Eye and skin irritation, abdominal pain, bronchospasm, shortness of breath, decreased respiratory rate, acute kidney failure	• Remove from source of exposure • Provide fresh air (fumes are toxic) • Decontaminate • Flush eyes with water • Shower to cleanse skin • Administer oxygen as needed • If swallowed, don't induce vomiting • Administer activated charcoal or gastric lavage
Arsenic Poisoning (Contaminated groundwater, tobacco smoke, hide tanning, and pressure treated wood)^{19,20}	Nausea/vomiting, abdominal pain, diarrhea, paresthesias, muscle cramping, skin pigmentation changes, skin lesions and cancers, cardiac dysrhythmias, death	• Decontaminate skin and hair • Test urine for arsenic (it is rapidly cleared from blood) • Test hair follicles, fingernails, and skin for long-term exposure • Administer activated charcoal • Administer chelation therapy with dimercaprol or DMSA • Administer IV fluids to maintain urine output • Provide continuous cardiac monitoring • Identify and remove source of exposure

18. Agency for Toxic Substances and Disease Registry. (2014, October 21). *Medical management guidelines for formaldehyde*. Centers for Disease Control and Prevention. <https://wwwn.cdc.gov/TSP/MMG/MMGDetails.aspx?mmgid=216&toxid=39>
19. World Health Organization. (2018, February 15). *Arsenic*. <https://www.who.int/news-room/fact-sheets/detail/arsenic>
20. Goldman, R. H. (2020, October 8). Arsenic exposure and poisoning. *UpToDate*. Accessed April 3, 2022, from www.update.com

Mercury (Thermometers, sphygmomanometers, fluorescent light bulbs, amalgam tooth fillings, and contaminated fish)²¹	Acute inhalation exposure in occupational settings may cause cough, dyspnea, chest pain, excessive salivation, inflammation of gums, severe nausea/vomiting, diarrhea, dermatitis	• Remove from source of exposure • Blood or urine mercury tests • If inhaled, oxygenation, bronchodilators, chelation treatment • If ingested, administer chelation therapy • Fish with 0.3 to 0.49 ppm of mercury can be safely consumed three times per month but those with greater than 0.5 ppm should be avoided
Radon Gas (Naturally occurring gas resulting from the decay of trace amounts of uranium found in the earth's crust)²²	Persistent cough, hoarseness, wheezing, shortness of breath, coughing up blood, chest pain, frequent respiratory infections like bronchitis and pneumonia, loss of appetite, weight loss, fatigue, lung cancer	• Measure levels of radon in the home (testing kits available) • Install radon mitigation system in home • Provide public education

21. Beauchamp, G., Kusin, S., & Elinder, C. (2022, February 1). *Mercury toxicity*. UpToDate. Accessed April 3, 2022, from www.update.com

22. National Radon Defense. (n.d.). *Radon symptoms*. <https://www.nationalradondefense.com/radon-information/radon-symptoms.html>

Infectious Disease (HIV, hepatitis, sexually transmitted diseases, and COVID-19)	Symptoms are based on disease process	• Blood tests for HIV, hepatitis, syphilis • Quarantine and contact trace as indicated by health department • Implement transmission-based precautions based on route of transmission • Provide public education about the disease and how it is spread • Report communicable disease based on state reporting requirements. Each state has requirements for reporting communicable disease to the Department of Health. For example, see ▶ Wisconsin's Department of Health Communicable Disease Reporting Requirements or ▶ Minnesota's Department of Health Communicable Disease Reporting Requirements.

Frostbite (Overexposure of skin to cold) ²³	White or grayish color of exposed skin, may be hard or waxy to touch; lack of sensitivity to touch or numbness and tingling; clear or blood-filled blisters after thawing; cyanosis after rewarming indicates necrosis	• Remove wet clothing • Warm skin slowly in warm (not hot) water or with body heat • Do not rub area or allow walking on frostbitten feet because of potential tissue damage • May administer tPA for severe injury with thrombosis
Organophosphates (Insecticides and bioterrorism nerve agents) ²⁴	Acute onset of symptoms related to cholinergic excess: bradycardia, increased salivation, tearing, urination, vomiting and diarrhea, diaphoresis, paralysis, respiratory failure, hypotension, seizures Intermediate syndrome: neck flexion weakness, cranial nerve abnormalities, muscle weakness	• Remove from source of exposure • Aggressively decontaminate • Administer 100% oxygen (may require endotracheal intubation) • Monitor RBC acetylcholinesterase • Administer atropine (prevents cholinergic activation) • Administer IV fluids for hypotension • Administer benzodiazepines for seizures

23. Zafren, K., & Mechem, C. C. (2021, February 1). Frostbite: Emergency care and prevention. *UpToDate*. Accessed April 3, 2022, from www.update.com

Bioterrorism (Anthrax, smallpox, nerve agents, and ricin) ²⁵	Symptoms are based on the agent	• Activate 911 • Decontaminate as indicated • Manage ABCs • Coordinate with emergency management officials

- ▶ Access up-to-date, evidence-based information for suspected poisoning at the [Poison Control Center](#) or call 1-800-222-1222.
- ▶ Read more the U.S. Department of Homeland Security and the U.S. Department of Health and Human Services's [Patient Decontamination in a Mass Chemical Exposure Incident PDF](#).

Recovery

During the recovery period, restoration efforts occur concurrently with regular operations and activities. The recovery period from a disaster can be prolonged. Examples of recovery activities include the following²⁶:

24. Bird, S. (2021, September 23). Organophosphate and carbamate poisoning. *UpToDate*. Accessed April 3, 2022, from www.update.com
25. Adalja, A. A. (2022, January 10). Identifying and managing casualties of biological terrorism. *UpToDate*. Accessed April 3, 2022, from www.update.com
26. Emergency Management Institute. (2013). *ISS-111.A: Livestock in disasters*. Federal Emergency Management Agency. <https://training.fema.gov/is/courseoverview.aspx?code=iss-111.a&lang=en>

- Preventing or reducing stress-related illnesses and excessive financial burdens
- Rebuilding damaged structures
- Reducing vulnerability to future disasters

When people are affected by a disaster, they may respond in a variety of different ways. It is natural and expected to respond to a disaster with emotions such as fear, worry, sadness, anxiety, depression, and despair. Many people exhibit **resiliency**, the ability to cope with adversity and recover emotionally from a traumatic event.²⁷ However, the mental health of the population must be considered and monitored during recovery from any disastrous event. For example, some people may relive previous traumatic experiences or revert to using substances to cope. Behavioral health responses such as post-traumatic stress disorder (PTSD), substance use disorder, and increased risk for suicide should always be considered when assessing individuals' responses to a disaster.

Effects from trauma extend beyond the physical damages from any disaster. It may take time for individuals to recover physically and emotionally. Survivors of a community disaster should be encouraged to take steps to support each other to promote adaptive coping. Use the following box to read additional information in the “Tips for Survivors of a Traumatic Event” handout by the Substance Abuse and Mental Health Services Administration (SAMHSA).

27. Substance Abuse and Mental Health Services Administration. (2022, March 23). *Disaster preparedness, response, and recovery*. U.S. Department of Health & Human Services. <https://www.samhsa.gov/disaster-preparedness>

View a supplementary YouTube video²⁸ on disaster management and triage: [Disasters and Triage: Community Health – Fundamentals of Nursing | @LevelUpRN](#)

▶ Read the SAMHSA handout on “[Tips for Survivors of a Traumatic Event](#)” PDF.

▶ Review concepts related to loss and the stages of grief in the “[Grief and Loss](#)” chapter of *Open RN Nursing Fundamentals*.

Agencies Providing Emergency Assistance

Many federal, state, and local agencies provide support to communities during disasters. The Federal Emergency Management Agency (FEMA) is the agency that promotes disaster mitigation and readiness and coordinates response and recovery following the declaration of a major disaster. FEMA defines a disaster as an event that results in large numbers of deaths and injuries; causes extensive damage or destruction of facilities that provide and sustain human needs; produces an overwhelming demand on state and local

28. Level Up RN. (2023, June 21). *Disasters and triage: community health – fundamentals of nursing* | @LevelUpRN [Video]. YouTube. All rights reserved. https://www.youtube.com/watch?v=VA_W6OHLx5M

response resources and mechanisms; causes a severe long-term effect on general economic activity; and severely affects state, local, and private sector capabilities to begin and sustain response activities.²⁹ FEMA employees represent every U.S. state, local, tribal, and territorial area and are committed to serving our country before, during, and after disasters.

Disasters are declared using established guidelines and procedures. Because all disasters are local, they are initially declared at the local level. This declaration is typically made by the local mayor. When the mayor determines that capabilities of local resources have been or are expected to be exceeded, state assistance is requested. If the state chooses to respond to a disaster, the governor of the state will direct implementation of the state's emergency plan. If the governor determines that the resource capabilities of the state are exceeded, the governor can request that the president declare a major disaster in order to make federal resources and assistance available to qualified state and local governments. This ordered sequence is important to ensure appropriate financial assistance.³⁰

A **state of emergency** is declared when public health or the economic stability of a community is threatened, and extraordinary measures of control may be needed. For example, an infectious disease outbreak like COVID-19 can cause the declaration of a state of emergency. A county or municipal agency is designated as the local emergency management agency, and local law specifies the chain of command in emergencies. Use the following box to access more information about federal and local agencies that provide emergency assistance.

29. Emergency Management Institute. (2013). *ISS-111.A: Livestock in disasters*. Federal Emergency Management Agency. <https://training.fema.gov/is/courseoverview.aspx?code=is-111.a&lang=en>

30. Emergency Management Institute. (2013). *ISS-111.A: Livestock in disasters*. Federal Emergency Management Agency. <https://training.fema.gov/is/courseoverview.aspx?code=is-111.a&lang=en>

Examples of Organizations That Provide Emergency Assistance

Federal

- ▶ [Federal Emergency Management Agency \(FEMA\)](#)
- ▶ [Strategic National Stockpile](#)
- ▶ [Cybersecurity and Infrastructure Security Agency \(CISA\)](#)

Local

- ▶ [Local FEMA agencies \(each state\)](#)
- ▶ [American Red Cross](#)

Local county emergency management divisions

18.4 Nurse Roles in Emergency Response

Together with emergency personnel, community organizations, health care providers, and other members of the health care team, nurses play a key role in carrying out emergency response plans. Before, during, and after disasters, nurses provide education and health promotion interventions to protect the community and keep people safe from environmental hazards. During the emergency response, nurses assist in first aid, triage clients' needs, direct victims to resources and community support, and continuously assess and monitor clients' physical and psychological needs. Nurses also assist with community organization through logistical organization of response and prevention needs, such as coordination of blood drives, clothing drives, management of shelters, and other social needs that exist in the community. When disaster strikes, nurses are challenged to use their skills and scope of practice to the fullest to provide the best care for their community.¹

► See an example [Disaster Nursing Timeline on page 250](#) of *The Future of Nursing 2020-2030 : Charting a Path to Achieve Health Equity* ebook.

The ability to care for and protect vulnerable citizens depends substantially on the preparedness of the nursing workforce. The nursing workforce available to participate in U.S. disaster and public health emergency response includes all licensed nurses (licensed practical/vocational nurses [LPNs/LVNs] and registered nurses [RNs]), civilian and uniformed services nurses at the federal and state levels, nurses who have recently

1. National Academies of Sciences, Engineering, and Medicine. (2021). *The future of nursing 2020-2030: Charting a path to achieve health equity*. National Academies Press. <https://doi.org/10.17226/25982>

retired, and nurses who volunteer in organizations (e.g., National Disaster Medical System, Medical Reserve Corps, National Voluntary Organizations Active in Disasters, and the American Red Cross). Each of these entities plays a critical role in the nation's ability to respond to and recover from disasters and large-scale public health emergencies such as the COVID-19 pandemic.² The increasing frequency of natural and environmental disasters, along with public health emergencies such as the COVID-19 pandemic, highlights the critical importance of having a national nursing workforce prepared with the knowledge, skills, and abilities to respond.³

Nurse Roles in Pandemics and Other Infectious Disease Outbreaks

When infectious disease outbreaks occur, nurses are called to the front lines to care for clients very quickly. In the past few decades, infectious disease outbreaks have been occurring more frequently and with more intensity, and nurses, along with health care agencies, must be prepared to respond to such emergencies. Some of the ways nurses respond are by doing the following⁴:

- Tracking disease prevalence and epidemiology of diseases
- Assisting with screening and testing, along with vaccine distribution
- Providing direct care to affected individuals in hospitals and outpatient

2. National Academies of Sciences, Engineering, and Medicine. (2021). *The future of nursing 2020-2030: Charting a path to achieve health equity*. National Academies Press. <https://doi.org/10.17226/25982>

3. National Academies of Sciences, Engineering, and Medicine. (2021). *The future of nursing 2020-2030: Charting a path to achieve health equity*. National Academies Press. <https://doi.org/10.17226/25982>

4. National Academies of Sciences, Engineering, and Medicine. (2021). *The future of nursing 2020-2030: Charting a path to achieve health equity*. National Academies Press. <https://doi.org/10.17226/25982>

clinics

- Educating the public and community about disease prevention and treatment
- Providing psychological support to those fearful of the emergency

New infectious diseases require nurses to receive continuing education regarding infection prevention, diagnosis, treatment, and health promotion. This may include gaining new knowledge about medications, transmission precautions, personal protective equipment (PPE), and evidence-based nursing interventions and medical treatments. Nurses must use critical thinking and apply new evidence-based practices to provide quality care to individuals in their community affected by disease.

The Impact of the COVID-19 Pandemic on Nurses

In December 2019 the novel coronavirus, known as COVID-19, was first detected in China. By March 2020 the World Health Organization declared a worldwide pandemic for what has been called the worst public health emergency in the past 100 years. By March 2022 almost 80 million cases were identified in the United States, with over 977,000 deaths. Worldwide, over 488 million cases were diagnosed, with over 6 million deaths.^{5,6}

► View the CDC's [Covid Data Tracker](#) or [Our World in Data's Data Tracker](#) for up-to-date COVID information.

5. Centers for Disease Control and Prevention. (n.d.). *COVID data tracker*. <https://covid.cdc.gov/covid-data-tracker/#datatracker-home>

6. [Daily new confirmed COVID-19 feathers per million people](#) by [Our World in Data](#) is licensed under [CC BY 4.0](#)

The COVID-19 pandemic created a health care environment never before seen in modern times. Nurses were called upon to care for clients, often lacking proper personal protective equipment (PPE) and medical equipment, to properly support client health. They cared for clients above and beyond the acuity that they normally managed in their area of expertise and provided frequent end-of-life care. They communicated regularly by phone with loved ones of clients who were dying due to quarantine guidelines and visitor limitations. Staffing shortages became critical as illness spread to nurses and their family members.⁷

As a result, thousands of nurses were still stressed, frustrated, and overwhelmed two years into the pandemic. In October 2021 the American Nurses Association found the following in a mental health and wellness survey of nurses⁸:

- Over 34% rated their emotional health as not, or not at all, emotionally healthy.
- 42% reported having an extremely stressful, disturbing, or traumatic experience due to COVID-19.
- Among nurses who said they intend to leave their position in the next six months, 48% cited the top reason as work negatively affecting their health and well-being, followed closely by insufficient staffing (41%).

The American Nurses Foundation Executive Director, Kate Judge stated, “The

7. National Academies of Sciences, Engineering, and Medicine. (2021). *The future of nursing 2020-2030: Charting a path to achieve health equity*. National Academies Press. <https://doi.org/10.17226/25982>

8. American Nurses Foundation. (2021, October 26). *New survey data: Thousands of nurses are still stressed, frustrated, and overwhelmed almost 2 years into the pandemic*. [News release]. <https://www.nursingworld.org/news/news-releases/2021/american-nurses-foundation-releases-comprehensive-survey-about-nurses/>

COVID-19 pandemic is not over yet, and its impact will persist for a long time. Its challenges have left the nursing profession in a particularly vulnerable state, exacerbating nurse staffing shortages, and negatively impacting nurses' quality of life. Nurses are playing a pivotal role in efforts to end this pandemic, so we must ensure nurses are physically and psychologically safe and healthy to function optimally in caring first for themselves, their families, clients, and communities. A robust nursing workforce is essential to our nation's health and, therefore, nurses' well-being and mental health must be a top priority. The data collected from this survey overwhelmingly demonstrate the need to provide consistent and comprehensive support for our nation's nurses."⁹

- ▶ The American Psychiatric Nurses Association provides [COVID Resources](#) to support nurses as they address concerns and promote mental health as a result of the COVID-19 pandemic.

Preventing and Managing Stress in Disaster Responders

Engaging in disaster and emergency response work can cause emotional distress for nurses and first responders. Depending on the nature of the event, sources of stress may include exposure to scenes of human suffering, risk for personal harm, life-and-death decision-making, intense workloads, limited resources, and separation from family members who may also be in

9. American Nurses Foundation. (2021, October 26). *New survey data: Thousands of nurses are still stressed, frustrated, and overwhelmed almost 2 years into the pandemic*. [News release]. <https://www.nursingworld.org/news/news-releases/2021/american-nurses-foundation-releases-comprehensive-survey-about-nurses/>

harm's way. Use the link in the following box to view a SAMSHA brochure outlining tips for coping with stress after a disaster or traumatic event.

- ▶ Read the [Disaster Distress Helpline](#) PDF brochure from the SAMHSA on tips for coping with stress after a disaster.

- ▶ Read more information about stress in the health care system and self-care in the “[Burnout & Self-Care](#)” chapter of *Open RN Nursing Management and Professional Concepts*.

18.5 Spotlight Application

Sam, a nurse who works at the local hospital, hears about a flooding disaster in a nearby community. Major roads are flooded, and grocery stores have been destroyed. Power lines were knocked down during the storm, and cell phone service is not working. Sam starts to wonder, “What if?”... “What if a disaster happens here and I’m not home with my family – how will I know if they are safe? How will I stay safe? What obligations will I have at work?”

As a compassionate nurse, Sam feels a need to respond to others in a crisis but also has a concern about ensuring the well-being of his family members. A Google search reveals the American Nurses Association document “[Who Will Be There?](#)” PDF. He realizes the discomfort he is feeling about responding to a potential future disaster event is due to the conflict of ethical principles regarding the nurse’s obligation to care for others, as well as the obligation to care for oneself.¹ He decides to respond to this ethical dilemma by preparing his personal response should a disaster occur.

Sam reads additional information called “Make a Plan” provided by the U.S. Department of Homeland Security’s website “[!\[\]\(dfbd6b3763a6d1d9afaa974f64e2e4b5_img.jpg\) Ready.gov](#)”² Several questions come to mind as Sam reflects on his anticipated response to a disaster:

1. How will I receive alerts and warnings about a disaster in my community?
2. Are there any laws in my state that require my participation as a nurse in disaster response?
3. What is my employer’s emergency response plan? What is my expected

1. American Nurses Association. (2017). *Who Will Be There? Ethical, the law, and a nurse’s duty to respond in a disaster.*

https://www.nursingworld.org/~4ad845/globalassets/docs/ana/who-will-be-there_disaster-preparedness_2017.pdf

2. U.S. Department of Homeland Security. (2022, May 18). *Make a plan.*

<https://www.ready.gov/plan>

role as an employed nurse?

4. What state and local disaster preparedness plans currently exist in my community?
5. How will I get to work safely if a disaster occurs?
6. How will I communicate with my family members and ensure their safety if a disaster occurs?

Sam reads additional information provided by the Federal Emergency Management Agency (FEMA) and starts to create his [personal and family disaster plan PDF](#).³

Reflective Questions:

1. Consider the questions Sam posed as he considered his potential disaster response. What additional questions do you have about your role in a disaster response? What are the answers to these questions in your community and at your place of employment?
2. Create your own personal and family disaster plan.

3. FEMA. (2018). *Create your family emergency communication plan* [PDF]. <https://www.ready.gov/sites/default/files/2021-04/family-emergency-communication-plan.pdf>

18.6 Learning Activities



An interactive H5P element has been excluded from this version of the text. You can view it online here:

<https://wtcs.pressbooks.pub/nursingmhcc/?p=1074#h5p-59>

1



An interactive H5P element has been excluded from this version of the text. You can view it online here:

<https://wtcs.pressbooks.pub/nursingmhcc/?p=1074#h5p-60>

2



1. “Environmental Health and Emergency Preparedness Crossword” by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)
2. “Environmental Health and Emergency Preparedness Drag and Drop” by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)

- ▶ Test your clinical judgment with a NCLEX Next Generation-style question: [Chapter 18, Assignment 1](#)³

- ▶ Test your clinical judgment with a NCLEX Next Generation-style case study: [Chapter 18, Case Study 1](#)⁴



3. "Environmental Health and Emergency Preparedness Next Gen Question 1" by [OpenRN](#) is licensed under [CC BY-NC 4.0](#)

4. "Environmental Health and Emergency Preparedness Next Gen Case Study 1" by Kellea Ewen is licensed under [CC BY-NC 4.0](#)

XVIII Glossary

Chelation therapy: Treatment for heavy metal poisoning such as mercury, arsenic, and lead. Chelators are medications that bind to the metals in the bloodstream to increase urinary excretion of the substance.

Decontamination: Any process that removes or neutralizes a chemical hazard on or in the client in order to prevent or mitigate adverse health effects to the client; protect emergency first responders, health care facility first receivers, and other clients from secondary contamination; and reduce the potential for secondary contamination of response and health care infrastructure.

Disaster: A serious disruption of the functioning of a community or a society at any scale due to hazardous events interacting with conditions of exposure, vulnerability, and capacity that lead to human, material, economic, and environmental losses and impacts.

Disaster management: Response to a disaster with integration of emergency response plans throughout the life cycle of a disaster event.

Emergency preparedness: The planning process focused on avoiding or ameliorating the risks and hazards resulting from a disaster to optimize population health and safety. The process includes four key concepts: preparedness, mitigation, response, and recovery. Evaluation occurs after a disaster event as the planning process continues.

Environmental health hazard: A substance or pathogen that has the ability to cause an adverse health event in individuals or communities.

Mitigation: Actions taken to prevent or reduce the cause, impact, and consequences of disasters.

Preparedness: Planning, training personnel, and providing educational activities regarding potential disastrous events. Planning includes evaluating environmental risks and social vulnerabilities of a community.

Recovery: Restoration efforts occur concurrently with regular operations and

activities, such as preventing or reducing stress-related illnesses and excessive financial burdens.

Resiliency: The ability to cope with adversity and recover emotionally from a traumatic event.

Response: Actions taken in the immediate aftermath of a disaster, such as saving lives, treating injuries, and minimizing the effects of the disaster. Immediate needs are addressed, such as medical treatment, shelter, food, and water, as well as psychological support of survivors.

Simple Triage and Rapid Treatment (START): A triage system from the U.S. Department of Health and Human Services that prioritizes victims by color (red, yellow, green, and black) for efficient and effective treatment.

Social vulnerability: The characteristics of a person or a community that affect their capacity to anticipate, confront, repair, and recover from the effects of a disaster.

State of emergency: Status that is declared when the public health or the economic stability of a community is threatened, and extraordinary measures of control may be needed.

Triage: Prioritizing care for individuals affected by a disaster or emergency.

PART XIX

ANSWER KEY

Chapter 1

Answers to interactive elements are given within the interactive element.

Chapter 2

Answers to interactive elements are given within the interactive element.

Chapter 3

Answers to interactive elements are given within the interactive element.

Chapter 4

Answers to interactive elements are given within the interactive element.

Chapter 5

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Chapter 6

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Chapter 7

Answers to interactive elements are given within the interactive element.

Chapter 8

Answers to interactive elements are given within the interactive element.

Chapter 9

Answers to interactive elements are given within the interactive element.

Chapter 10

Critical Thinking Questions

1. DSM-5 lists these as unique mental health illness diagnoses, but the symptoms of each may cross over. In obsessive-compulsive personality disorder, the client exhibits orderliness and perfectionism. However, in personality disorders, the behaviors do not come and go or fluctuate, and there is no insight that the behavior is abnormal. In fact, clients typically believe their behavior is normal and beneficial. Additionally, the client does not perform repetitive actions that are classic to OCD. In contrast, OCD is caused by anxiety, and the severity of the obsessions and compulsions vary according to the level of anxiety. Clients with OCD exhibit repetitive actions such as excessive handwashing or repeatedly checking the door is locked or counting items. Clients have insight into the behavior and view it as abnormal and distressing, so they are more likely to seek treatment.
2. Name that personality disorder:
 - a. Histrionic
 - b. Paranoid
 - c. Borderline
 - d. Schizoid
 - e. Dependent
 - f. Antisocial
 - g. Avoidant
 - h. Narcissistic
 - i. Obsessive-Compulsive
 - j. Schizotypal
3. Check your medication knowledge:
 - a. Low-dose antipsychotics
 - b. Mood stabilizers and low-dose antipsychotics
 - c. Mood stabilizers and omega-3
4. Compare normal adolescent development with trait similarities of personality disorders:

- a. Cluster A: May not trust others, prefers to be alone, and may have magical thinking (imagination)
- b. Cluster B: Disregards right from wrong, lies, gets into trouble, impulsive, overreactive, emotional, and easily influenced by others
- c. Cluster C: Social discomfort, shy, fearful, and lacks self-confidence

Answers to interactive elements are given within the interactive element.

Chapter 11

Answers to interactive elements are given within the interactive element.

Chapter 12

Answers to interactive elements are given within the interactive element.

Chapter 13

Questions:

1. What symptoms of an eating disorder is Tiffany demonstrating? *Tiffany is exhibiting symptoms of anorexia nervosa.*
2. What other assessment findings does the nurse anticipate? (See *Table 13.3a – Chapter 13*)
3. What laboratory tests will likely be ordered during this visit? *Laboratory tests may include a complete blood count, electrolyte levels, glucose level, thyroid function tests, erythrocyte sedimentation rate (ESR), and creatine phosphokinase (CPK).*
4. What type of psychotherapy would be helpful for Tiffany? *Cognitive behavioral therapy and family-based therapy would be useful psychotherapy treatments for Tiffany.*
5. What conditions would cause Tiffany to be hospitalized? *Tiffany would be hospitalized if her vital signs are unstable, laboratory findings present acute health risk, and she has rapidly worsening symptoms or suicidal ideation with a plan and is unable to contract for safety.*
6. Tiffany is hospitalized. Create a brief nursing care plan for Tiffany including a nursing diagnosis, SMART goal, and 3-5 nursing interventions.

Diagnosis: Imbalanced Nutrition: Less Than Body Requirements

SMART Goal: Client will gain at least one pound weekly until reaching healthy weight classification according to her BMI.

Sample Interventions:

- *The client will be weighed on Mondays, Wednesdays, and Fridays and progress determined based on a target weight established by the dietician.*
- *A pleasant, calm atmosphere will be provided at mealtimes.*
- *The client will be observed during meals to prevent hiding or throwing away food and at least one hour after eating to prevent purging.*

- *The client will be encouraged to make her own menu choices as she approaches her goal weight.*
- *Knowledge and skills gained from individual, family, and group therapy sessions will be reinforced with the client and her family.*

Answers to interactive elements are given within the interactive element.

Chapter 14

Answers to interactive elements are given within the interactive element.

Chapter 15

Answers to interactive elements are given within the interactive element.

Chapter 16

Answers to interactive elements are given within the interactive element.

Chapter 17

Answers to interactive activities are provided within the activity.

Chapter 18

Answers to interactive elements are given within the interactive element.