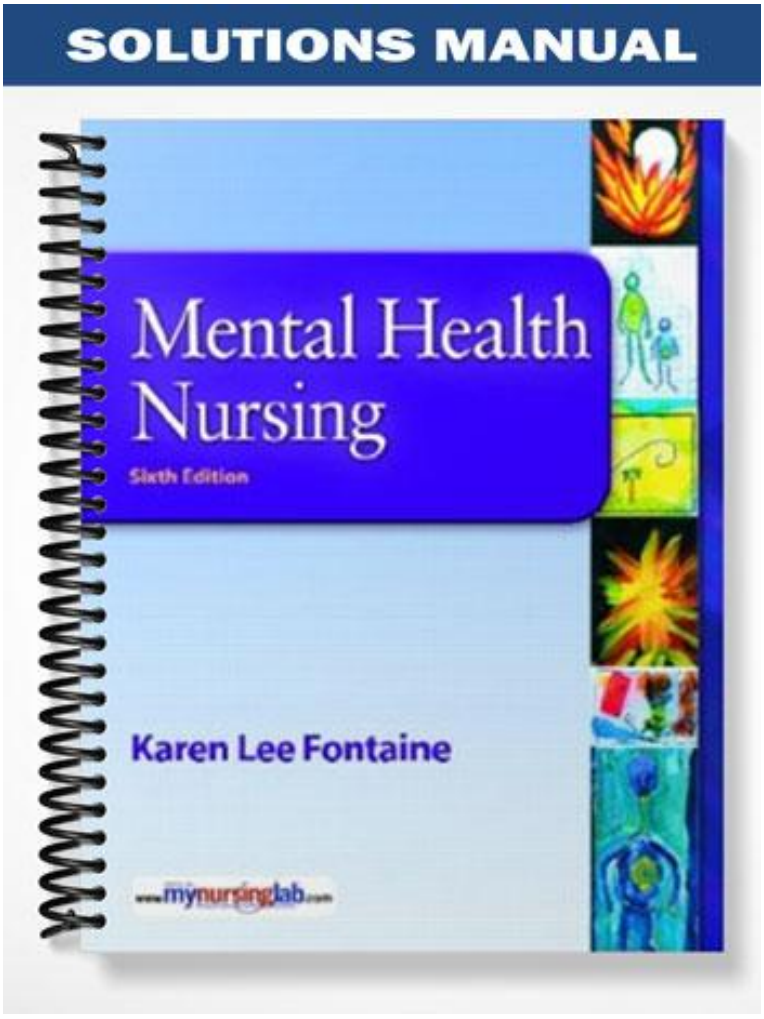
SOLUTIONS MANUAL



CHAPTER 2

THE FAMILY IN MENTAL HEALTH NURSING

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Figure 2.1 Circumplex model.

Photo 2.1 Competent families have an emotional climate of intimacy and predictability.

Photo 2.2 Children experience the same emotions of grief as adults.

Photo 2.3 Cultural differences exert a profound influence on how parents and children relate to one another.

Table 2.1 Differences Between Depression and Grief

Table 2.2 The Language of Family Pain

Box 2.1 Characteristics of Family Cohesion

Box 2.2 Characteristics of Family Flexibility

Box 2.3 Assessing Rules in Your Family of Origin

Box 2.4 Factors Influencing Outcomes in Mourning

Box 2.5 Family Orientations

LEARNING OBJECTIVE 1

Outline the elements of the family system.

CONCEPTS FOR LECTURE	POWERPOINT LECTURE SLIDES

1. Family is defined as two or more people related by birth, marriage, formal or informal adoption, or choice. Families have been labeled in the past as functional or dysfunctional. Psychiatric nursing has moved to viewing families through a competency model. The competency model is based on the belief that families are resourceful and have the capacity to grow and change. The model does not ignore pathology or dysfunction, but emphasizes strength, adaptation, and resources. Family systems are complex, and understanding the interactions will provide a general idea of how well the family is able to adapt and function. 2. Family communication is measured by listening skills, speaking skills, self-disclosure, and tracking. Families who communicate well are better able to adapt and cope. The family's ability to resolve conflict is based on the family's capacity to discuss, negotiate, and reach agreement on	*(NOTE: The number on each PPT Lecture Slide directly corresponds with the Concepts for Lecture.)* 1 Definition of Family Family is defined as two or more persons related by: • Birth • Marriage • Formal or informal adoption • Choice 1a Competency Model The competency model is based on the belief that families are resourceful and have the capacity to grow and change. The model emphasizes: • Strength • Adaptation • Resources 2 Communication

areas of difference.

3. Boundaries (social constructs that are culturally determined) are invisible lines that define the amount and kind of contact allowable among members of the family. They define divisions among the spousal, parental, and sibling subsystems and are clear, rigid, or diffuse.

4. Family cohesion is the emotional bonding of family members with one another. In developed societies, it is believed that the central ranges of cohesion (separated and connected) contribute to optimal family competency, and the extremes (disengaged or enmeshed) are seen as less adaptive. (Source: Box 2.1 Characteristics of Family Cohesion)

5. Family flexibility is the amount of change in a family's leadership, role relationships, and relationship rules. It also refers to the family's ability to respond to stress. Structured and flexible ranges (central) are more con-

- Listening
- Speaking
- Self-disclosure
- Tracking

3 Boundaries

- Clear
  - Firm, yet flexible
- Rigid
  - Isolated, with little room for negotiation and individual development
- Diffuse
  - Little distinction between family members; too much negotiation, resulting in loss of autonomy

4 Cohesion

See Box 2.1 Characteristics of Family Cohesion

5 Flexibility

See Box 2.2 Characteristics of Family

ducive to family adaptation, with rigid and chaotic (extremes) being less competent. Rules determine appropriate leadership and relationship roles. (Source: Box 2.2 Characteristics of Family Flexibility, Figure 2.1 Circumplex Model) 6. Emotional availability, the quality of parent-child interactions, includes assessment areas of parental sensitivity, parental structuring, parental nonintrusiveness, and nonhostility. 7. Family competency includes the family's relational resources and adaptive abilities and indicates the ability of the family to productively manage stress. Adaptive families are resilient; they evolve and shift with changing situations.	Flexibility 5a Flexibility, *continued* See Figure 2.1 Circumplex model 6 Emotional Availability • Parental sensitivity • Parental structuring • Parental nonintrusiveness • Nonhostility 7 Resiliency • Resiliency ◦ The most distinctive trait of competent families is the ability to productively manage stress.

SUGGESTIONS FOR CLASSROOM ACTIVITIES	**SUGGESTIONS FOR CLINICAL ACTIVITIES**
• Discuss the importance of incorporating current research findings when attempting to determine risk factors for family functioning.	• During a clinical visit, have the students interview clients about their views of their own family's system, what is considered normal in their culture, and in what ways

• Ask students to complete the sentences in Box 2.3 Assessing Rules in Your Family of Origin in the text. Discuss the similarities/differences of functioning of families.	they think their family did/did not fit their cultural norms. • Have students discuss patterns among the clients they interviewed.

LEARNING OBJECTIVE 2

Discuss the impact of grief and loss on the family system.

CONCEPTS FOR LECTURE	POWERPOINT LECTURE SLIDES
1. Coming to terms with death is a difficult task that all families must confront. Prior experiences with death and loss influence how families grieve. Grief includes bereavement and mourning. Bereavement includes the feelings, thoughts, and responses to a death. Mourning is the active process of learning to adapt to the death and includes a series of phases. 2. No one grieves predictably or uniformly. The manner in which a person mourns is affected by one's family, religious beliefs, cultural customs, and gender. Family struc-	*(NOTE: The number on each PPT Lecture Slide directly corresponds with the Concepts for Lecture.)* 1 Grief and Loss • Bereavement 2 • Mourning • Not predictable or uniform • Family structure changes 3 Grief and Loss, *continued* • Disenfranchised grief ◦ Relationship not recognized

ture changes when a family member dies; roles are realigned and reassigned, and relationships change.

3. Every culture establishes grieving norms. Disenfranchised grief describes a loss that the culture dictates cannot be openly acknowledged, socially validated, or publicly mourned. Because people are capable of a great capacity for attachments, problems may result when grief is minimized or ignored.

4. Whether or not grief is termed *complicated* is based on the range and tolerance of differences in grieving allowed by the culture. Complicated grief is generally considered the presence of unremitting and incapacitating distress for at least 6 months and is associated with the presence of mental disorders. Individuals who experience complicated grief are at a higher risk for a variety of physical and mental health problems. Psychiatric complications include depres-

- ◦ Loss not recognized
- ◦ Griever not recognized

4 Grief and Loss, *continued*

- Complicated grief
  - ◦ Intrusive images
  - ◦ Severe feelings of emptiness
  - ◦ Neglect of activities

4a Grief and Loss, *continued*

See Table 2.1 Differences Between Depression and Grief

sive episodes, anxiety-related symptoms and disorders, suicidal ideation, or psychotic denial of the death. (Source: Table 2.1 Differences Between Depression and Grief)	

SUGGESTIONS FOR CLASSROOM ACTIVITIES	**SUGGESTIONS FOR CLINICAL ACTIVITIES**
• In pairs, have students role-play positive and negative characteristics of grief. How can they recognize these behaviors in others? • Have students discuss the factors influencing outcomes in mourning as they interview their clients in Box 2.4 Factors Influencing Outcomes in Mourning in the text.	• Have students ask staff on the clinical unit how they distinguish between depression and grief. • Interview clients from different cultures about how mourning is experienced in their culture.

LEARNING OBJECTIVE 3

Discuss the impact of mental illness on the family system.

CONCEPTS FOR LECTURE	**POWERPOINT LECTURE SLIDES**
1. Family members of individuals with mental illness share in the losses that accompany the illness. Families are the major source of	*(NOTE: The number on each PPT Lecture Slide directly corresponds with the Concepts for Lecture.)*

support and rehabilitation. Family burden is the overall level of distress experienced because of the mental illness. Objective family burden relates to actual, identifiable family problems. Families are impacted by the symptomatic behaviors of the client which can lead to loss of independence, increased family responsibility, disruption in household functioning, restriction of social activities, and financial hardship. Caregiving may become a burden when appropriate community services are unavailable. The stigma of mental illness may cause the family to become isolated and feel shame, thus limiting support. Subjective family burden is the psychological distress of the family members in relation to objective burden. Feelings of frustration, anxiety, depression, hopelessness, helplessness, grief, and loss are common. 2. Family recovery involves discovery and denial (stage one), recognition and acceptance	1 Family Impacts • Family burden • Objective • Stigma • Subjective 2 Family Impacts, *continued* Family Recovery • Stage 1 ◦ Discovery ◦ Denial • Stage 2 ◦ Recognition ◦ Acceptance 2a Family Impacts, *continued* Family Recovery • Stage 3 ◦ Coping ◦ Competence

(stage two), coping and competence (stage three), and personal and political advocacy (stage four). 3. In an effort to understand how mental health affects families, nurses must understand mental disorders across the life span (youth, adult, older adult, couples, pregnancy, and parenting).	• Stage 4 ◦ Personal advocacy ◦ Political advocacy 3 Mental Disorders Across the Life Span • Youth ◦ ~12–20% of children in the United States have a serious emotional disturbance and/or substantial functional impairment ◦ Family turmoil can trigger the onset of a disorder in biologically and/or genetically predisposed children 3a Mental Disorders Across the Life Span, *continued* • Pregnancy ◦ 10–15% of pregnant women meet the criteria for depression ◦ In the United States 50% of pregnancies are unplanned and the rate is

	higher among women who are severely and persistently mentally ill 3b Mental Disorders Across the Life Span, *continued* • Parenting ◦ In North America ~50% of adults with mental disorders have children living with them • Couples ◦ Most people who became severely ill at a young age remain single because their social functioning is limited ◦ 50% of couples with depression report serious couple difficulties 3c Mental Disorders Across the Life Span, *continued* • Older Adults ◦ By age 65, 12% of people have limitations with activities of daily living ◦ By age 85, 38% of people have limita-

	tions with activities of daily living ◦ Caregivers of older people with mental disorders are often depressed themselves

SUGGESTIONS FOR CLASSROOM ACTIVITIES	SUGGESTIONS FOR CLINICAL ACTIVITIES
• Present students with a case study of a client and family affected by mental illness. Have students present nursing interventions that may help the family cope with the burdens. • Have students bring in evidence-based articles on how mental health affects families across the life span. How much of the article addresses objective burden? Subjective burden? If there are quotes from family members, what stage of recovery do the quotes reflect?	• In the clinical setting, have students interview clients about how the client's illness has affected family members. What objective and subjective burdens are evident? • Have students observe clients of different ages. Are there patterns among clients of the same age?

LEARNING OBJECTIVE 4

Assess family functioning using the family competency model.

CONCEPTS FOR LECTURE	**POWERPOINT LECTURE SLIDES**
1. When conducting assessments, it is important to focus on the family as well as the client, because families are in a position to be affected by and to influence the course of an individual's problems. Family members are a source of information and should be involved in the treatment, psychoeducation, and family therapy. Assessment includes gathering information on how partners, parents, and children in the family experience or react to the client's symptoms. Family nurse therapists may use genograms, ecomaps, and/or pedigree analysis for family history assessments. Factors in assessing clients and their families include family communication, conflict resolution, boundaries, cohesion, flexibility, emotional availability, leadership patterns, and overall family functionality. 2. Relapse vulnerability assessment refers to the concern families have over their loved	*(NOTE: The number on each PPT Lecture Slide directly corresponds with the Concepts for Lecture.)* 1 Family Assessment • Discover family competence through questions • Utilize: ◦ Genograms ◦ Ecomaps ◦ Pedigree analysis 2 Family Assessment, *continued* • Assessing relapse vulnerability ◦ Family patterns that lead to relapse — Expressed emotion (EE) — Affective style (AS) 3 Family Assessment, *continued* • Cultural assessment

one's vulnerability to relapse. Two family patterns that measure family emotional climate are expressed emotion (EE) and affective style (AS). Clients in high EE and AS families have a higher relapse rate. The assessment should also include client compliance with medication regimens, substance use/abuse, family crises, vocational stress, interpersonal conflict, inconsistent daily routines, sleep deprivation, and family protective factors.

3. Cultural assessment considers how clients look at their cultural selves along a continuum between egocentricity (characteristics of individualism, separateness, autonomy, competition, and mastery of and control over one's environment) and sociocentricity (interdependent and interconnected and values cooperation, cohesiveness, group identity, and harmony with one's environment). (Source: Box 2.5 Family Orientations)

◦ A person's culture shapes their concept of self

— Egocentric self

— Sociocentric self

3a Family Assessment, *continued*

See Box 2.5 Family Orientations

SUGGESTIONS FOR CLASSROOM ACTIVITIES	SUGGESTIONS FOR CLINICAL ACTIVITIES
• Discuss the tools nurses use to assess family functioning. • Have the class break into groups and discuss what teaching plans they would use to help mental health clients and their families.	• Visit a mental health facility or group home. How resourceful are families and their clients? How does the nurse collaborate with other health care professionals to reach their goals? • Ask students to observe clients from different cultures in the clinical setting. How are the family orientations similar to or different from the orientations represented in Box 2.5 in the text?

LEARNING OBJECTIVE 5

Characterize the roles of mental health nurse in family nursing practice.

CONCEPTS FOR LECTURE	POWERPOINT LECTURE SLIDES
1. Nurses must be able to help families answer questions, identify feelings and reactions, and adopt more flexible beliefs about the nature of their problems. The nurse encourages effective coping strategies. To do this, nurses must be educators, life coaches, re-	*(NOTE: The number on each PPT Lecture Slide directly corresponds with the Concepts for Lecture.)* 1 Nursing Roles • Nurse as:

ferral agents, and spiritual caregivers.	◦ Educator ◦ Life coach ◦ Referral agent ◦ Spiritual caregiver

SUGGESTIONS FOR CLASSROOM ACTIVITIES	**SUGGESTIONS FOR CLINICAL ACTIVITIES**
• Have students discuss the various roles nurses have to encourage effective family coping strategies for mental health clients. • Have students develop teaching plans for each of the nursing roles. Are students more comfortable or confident in some of these roles than others?	• Explore the availability of mental health agencies within your community. Have students visit at least two agencies and compare/contrast the different roles nurses use when helping families with coping strategies. • Have students ask staff in the clinical setting what nursing roles they fill most often.

LEARNING OBJECTIVE 6

Design interventions to improve the functioning of clients and their families.

CONCEPTS FOR LECTURE	**POWERPOINT LECTURE SLIDES**
1. Psychoeducation has proven to be an important aspect of family nursing. Illness ed-	*(NOTE: The number on each PPT Lecture Slide directly corresponds with the Concepts*

ucation occurs in the context of the basic family unit and with multifamily groups. It is important to teach about mental illness—causes, symptoms, treatment choices, stressors, protective factors, and early signs of relapse. 2. Family education programs include conflict–management skills, problem-solving strategies, crisis plans, communication skills, assertiveness training, and responses to stigmatization and discrimination. The nurse should help families with high EE and AS to moderate their expression of emotion and their affective style. Communication skills help families learn new ways of talking and listening; thereby, reducing stress, solving problems, and improving relationships. Stress-management techniques, such as: relaxation exercises, visualization, affirmations, meditation, and physical exercise should be included. The nurse should help the family develop a social support sys-	*for Lecture.)* 1 Nursing Interventions • Psychoeducation 2 • Family education 3 • Spiritual care

tem and understand community resources and service delivery programs. Encourage networking with other families. 3. Provide spiritual care by supporting religious beliefs and activities, fostering family love, forgiveness, and acceptance, and encouraging clients to become active in their own care.	

SUGGESTIONS FOR CLASSROOM ACTIVITIES	SUGGESTIONS FOR CLINICAL ACTIVITIES
• Have students discuss the various interventions used to improve functioning in mental health clients and their family relationships. • Develop interventions for helping high EE and AS families to become more moderate.	• Explore the availability of mental health agencies within your community. Have students compare/contrast interventions used by nurses when helping mental health clients and their families. • Have students find the NAMI resources in the local area.