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Science and the Therapeutic Use of Self in Psychiatric-Mental Health Nursing

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http://evolve.elsevier.com/Varcarolis/essentials

OBJECTIVES

1. Explain what is meant by evidence-based practice (EBP), recovery model, and trauma-informed care models.
2. Identify the 5 A's used in the process of integrating EBP into the clinical setting.
3. Discuss at least three dilemmas nurses face when attempting to utilize EBP.
4. Identify four resources that nurses can use as guidelines for best-evidence interventions.
5. Identify basic principles of therapeutic self and apply them as an art of nursing.
6. Defend why the concept of caring should be a basic ingredient in the practice of nursing and how it is expressed while giving patient care.
7. Discuss what is meant by being a patient advocate.

KEY TERMS AND CONCEPTS

5 A's, p. 3
attending, p. 7
caring, p. 7
clinical algorithms, p. 4
clinical/critical pathways, p. 5
clinical practice guidelines, p. 4
evidence-based practice, p. 2
patient advocate, p. 7
psychiatric-mental health nursing, p. 2
Quality and Safety Education for Nurses, p. 2
recovery model, p. 6
therapeutic use of self, p. 6
trauma-informed care, p. 6

CONCEPT: ADVOCACY: *Advocacy* is a signature aspect of professional identity among nursing and other professions and is a primary consideration for all decisions made within the health care environment. It involves a commitment to patients' health, well-being, and safety. The ability to speak out assertively and credibly on behalf of patients or families is critical to effective advocacy (Giddens, 2017). Psychiatric-mental health nurses also function as advocates when they advise patients of their rights, solve the prescription problems of the homeless patient, engage in public speaking, write articles, and lobby congressional representatives to help improve mental health care, among other actions. It can take a great deal of courage to advocate for patients when we witness behaviors or actions of health care professionals that could have serious consequences.

INTRODUCTION

Psychiatric-mental health nursing is a specialized area of nursing based on evidence related to the neurobiology of psychiatric disorders, psychopharmacology and the effects of medications, and therapeutic relationships using evidence-based models like the recovery-based model and trauma-informed care. It is one of the few areas of nursing found in nearly every other specialty area. Having knowledge of psychiatric mental health will benefit every nurse.

Like all nursing specialties, psychiatric-mental health nursing employs both the *science* and the *art* of nursing. Included in the *science* of nursing are the major concepts of **evidence-based practice (EBP)**, the recovery model, trauma-informed care, and **Quality and Safety Education for Nurses (QSEN)**, as well as theories from a range of nursing, psychological, and neurobiological research. The *art* of nursing includes concepts like communication, empathy, and connection. The *art* of nursing is "To quiet the chaos, to sort through the mess, to hold your patients' hands, to look beyond the surface (St. John, 2020)." (American Nurses Association [ANA], 2017).

EVIDENCE-BASED PRACTICE

With the increased understanding of the biology of psychiatric illnesses beginning in the 1990s (termed the "decade of the brain"), treatment approaches rapidly evolved into more scientifically grounded methods, now known as EBP. In psychiatry, the evidence-based focus extends to treatment approaches in which there is scientific evidence for psychological and sociological modalities, as well as evidence related to the neurobiology of psychiatric disorders and psychopharmacology. The emergence of evidence-based nursing in the United States originated from the EBP movement in the medical community in England and Canada during the 1980s and 1990s. A noteworthy concept differentiating EBP in nursing from medicine is that the approach utilized

in nursing incorporates more than clinical research. EBP should also include patient preferences and a nurse's clinical knowledge and skill (Duke University, 2020).

Basing nursing practice on a systematic approach to care is not new. Florence Nightingale (1820–1910), the founder of modern nursing, would observe and document evidence leading to best practices. It was under her watch that nurses began to notice soldiers with clean bandages had better survival rates and she would then advocate for better access to clean bandages and better hygiene (Reinking, 2020). In 1860, Nightingale made a proposal that resulted in "the first model for systematic collection of hospital data using a uniform classification of diseases and operations," eventually forming the basis of the coding system used worldwide, the *International Statistical Classification of Diseases and Related Health Problems (ICD)* (The Lancet, 2019). Historically, mental health professionals in the United States have used the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* classifications rather than the *ICD* system. However, in 2013, the *DSM* and the *ICD,* 10th Revision, Clinical Modification *(ICD-10)* codes were aligned.

Hildegard Peplau (1909–1999), considered the mother of psychiatric nursing, had a passion for clarifying and developing the art and science of professional nursing practice and believed that a scientific approach was essential to the practice of psychiatric nursing (National Association of Clinical Nurse Specialists [NACNS], 2020). Her contributions went far beyond what she brought to the field of psychiatric nursing. She introduced the concept of advanced nursing practice and promoted professional standards and regulation through credentialing, among a multitude of other foundational contributions to nursing (NACNS, 2020).

It should be noted that psychiatry was one of the first medical specialties to extensively use randomized controlled trials. One of the founding principles of clinical psychology in the 1950s was that practice should be based on the results of experimental comparisons of treatment methods (Jackson, 2011). However, with limited scientific evidence for practice at that time, much of nursing care was based on tradition, personal experience, unsystematic trial and error, and the earlier experiences of nurses and others in the health care profession (Jackson, 2011). During that time, there was an increase in the publication of research-related journals.

EBP is the process of making clinical decisions based on available evidence, clinical experience, and patient preference. The balance between evidence, nursing experience, and patient preferences and values are fluid and the weight of one or more area may increase or decrease depending on the situation (Wilkinson, 2019). There is no magic formula for determining which should carry more influence. Although EBP is equated with effective decision making, avoidance of habitual practice, and enhanced clinical performance, there may be a tendency to overlook practical knowledge that can provide useful information for individualized and effective practice.

Numerous definitions delineate the multistep process of integrating EBP into clinical practice. One that is simply stated and apt is referred to as the 5 A's (Wichita State University Libraries, 2020):

1. **Ask a question.** Identify a problem or need for change for a specific patient or situation.
2. **Acquire literature.** Search the literature for scientific studies and articles that address the issue(s) of concern.
3. **Appraise the literature.** Evaluate and synthesize the research evidence regarding its validity, relevance, and applicability using criteria of scientific merit.
4. **Apply the evidence.** Choose interventions that are based on the best available evidence with the understanding of the patient's preference and needs.
5. **Assess the performance.** Evaluate the outcomes, using clearly defined criteria and reports, and document the results.

Evaluating the evidence is done through a hierarchical rating system (Fig. 1.1 and Table 1.1). Systematic reviews or meta-analyses of randomized controlled studies and evidence-based clinical practice

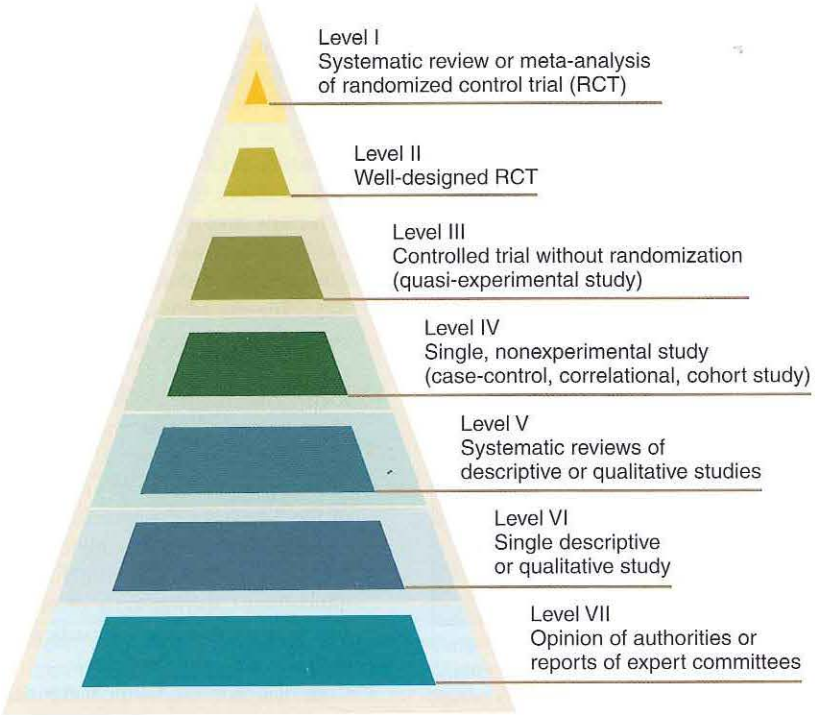

Fig. 1.1 Hierarchy of evidence. (From Melnyk, B. M., & Fineout-Overholt, E. [2014]. *Evidence-based practice in nursing & healthcare: A guide to best practice* [3rd ed.]. Philadelphia: Lippincott Williams & Wilkins; and Newhouse, R. P., Dearholt, S. L., Poe, S. S., et al. [2007]. *Johns Hopkins nursing: Evidence-based practice model and guidelines.* Indianapolis, IN: Sigma Theta Tau International.)

guidelines provide the strongest evidence on which to base clinical practice. In a randomized controlled trial (RCT), patients are chosen at random (by chance) to receive one of the clinical interventions or be in a control group with no treatment. One intervention would be the intervention under study, and another intervention might be the usual standard of care or a placebo. The weakest level of evidence includes expert committee reports, opinions, clinical experience, and descriptive studies. Although scientific evidence is ranked hierarchically, it is important to note the value of all types of evidence in clinical decision making.

The first Surgeon General's report published on the topic of mental health was in 1999 (U.S. Department of Health and Human Services [USDHHS], 1999). This landmark document was based on an extensive review of the scientific literature and created in consultation with mental health providers and consumers. The document concluded that there are numerous effective psychopharmacological and psychosocial treatments for most mental disorders. However, it raised some questions for psychiatric nurses, including the following:

- Are psychiatric nurses aware of the efficacy of the treatment and interventions they provide?
- Are they truly practicing evidence-based care?
- Is there documentation of the nature and outcomes of the care they provide?

TABLE 1.1 Hierarchy of Evidence and Grading of Recommendations[a]

HIERARCHY OF EVIDENCE		GRADING OF RECOMMENDATIONS	
Level	**Type of Evidence**	**Level**	**Type of Evidence**
Ia	Evidence from systematic reviews or meta-analyses of randomized controlled trials (RCTs)	A	Based on hierarchy I evidence
Ib	Evidence from at least one RCT		
IIa	Evidence from at least one controlled study without randomization	B	Based on hierarchy II evidence or extrapolated from hierarchy I evidence
IIb	Evidence from at least one other type of quasi-experimental study		
III	Evidence from nonexperimental descriptive studies, such as comparative studies, correlational studies, and case-control studies	C	Based on hierarchy III evidence or extrapolated from hierarchy I or II evidence
IV	Evidence from expert committee reports or opinions and/or clinical experience of respected authorities	D	Directly based on hierarchy IV evidence or extrapolated from hierarchy I, II, or III evidence

[a]Each recommendation has been allocated a grading that directly reflects the hierarchy of evidence on which it has been based. Please note that the hierarchy of evidence and the recommendation gradings relate the strength of the literature, not the clinical importance.
From Hierarchy of evidence and grading of recommendations. (2004). *Thorax, 59*(Suppl. 1), i13–i14.

The emphasis on EBP is expanding. However, this approach does not provide easy answers. For example, consider the following points:

- Who interprets "best evidence"?
- Not all nursing problems can be reduced to a clear issue that is solvable by scientific experiments.
- Relatively little higher-level nursing research addressing psychiatric nursing interventions and practice has been available.
- Despite the expectation to use EBP, little education is provided in undergraduate programs or in the workplace to prepare nurses for this process.
- How do nurses who are practicing in complex environments of reduced staffing and budgetary constraints find time to research and evaluate the literature and make decisions on "best evidence"?

Three basic aspects (or prongs) of EBP are the following:

- Evidence gleaned in review of the literature
- Clinical knowledge of the nurse from training and experience
- The desires of patients and the values for their care.

Case-study examples of how evidence-based practice is applied are highlighted in the Applying Evidence-Based Practice boxes throughout the clinical chapters.

Resources for Clinical Practice

1. *Internet resources.* A number of websites provide mental health resources for information, treatment provisions, and the results of recent clinical studies. Some of the most extensive databases for psychiatric and medical resources include Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed, and Cochrane reviews. There are self-tests for people to see if they may be experiencing symptoms of a specific disorder, such as depression, anxiety, or attention-deficit/hyperactivity disorder (ADHD). There are also resources for acquiring support and treatment. It is best to focus on sites that are maintained by professional societies, librarians, textbook publishers, or well-known organizations with a reputation for quality, evidence-based information.
2. *Clinical practice guidelines.* **Clinical practice guidelines** are based on appraising and summarizing the best evidence from literature review studies. They serve as tools for standardizing best evidence for formulating patient care and treatment plans. "Efficient and effective guidelines impact patient safety and quality by increasing the consistency of behavior and replacing idiosyncratic behaviors with best practices" (Keiffer, 2015, p. 328). The use of practice guidelines can increase the quality and consistency of care and facilitate outcome research. Essentially, practice guidelines (1) identify practice questions and explicitly identify all the decision options and outcomes; (2) identify the "best evidence" about prevention, diagnosis, prognosis, therapy, harm, and cost-effectiveness; and (3) provide decision points for deciding on a course of action. The *Clinical Practice Guidelines* of the American Psychiatric Association (APA) and the National Quality Measures Clearinghouse offer such guidelines. The U.S. Department of Health and Human Services sponsors a National Guidelines Clearinghouse of evidence-based guidelines pertaining to a wide range of medical and mental health conditions (http://www.guidelines.gov).
3. *Clinical algorithms.* **Clinical algorithms** are step-by-step guidelines prepared in a flowchart or decision-tree format. Alternative diagnostic and treatment approaches are described based on decision points using a large database relevant to the symptoms, diagnosis,

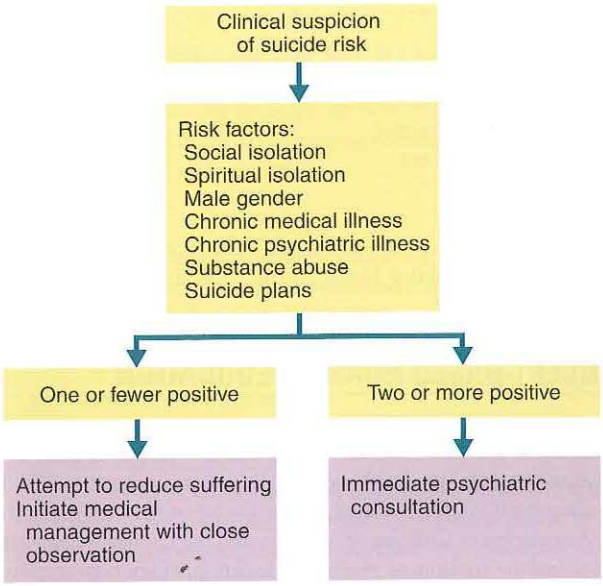

Fig. 1.2 Clinical algorithm for the suspicion of suicide risk. (Modified from Goldman, L., & Ausiello, D. [2008]. *Cecil medicine* [23rd ed.]. Philadelphia: Saunders.)

or treatment modalities. Fig. 1.2 depicts a clinical algorithm for the suspicion of suicide risk.

4. *Clinical/critical pathways.* **Clinical/critical pathways** are specific to the institution using them. These clinical pathways serve as a "map" for specified treatments and interventions to occur within specific time frames that have been shown to improve clinical outcomes. The interventions can include tests, health teaching, and medications. Each pathway lists the expected outcome using a measurable, time-specific format, and documentation is ongoing. Clinical pathways are one way that EBP can be integrated into clinical care.

The Research–Practice Gap

Unfortunately, there is a wide gap between the best-evidence treatments and their effective translation into practice. The need for continued research on how best to apply the findings of clinically relevant issues and their delivery into clinical practice has been the emphasis of the Institute of Medicine (IOM, 2006):

> … Research that has identified the efficacy of specific treatments under rigorously controlled conditions has been accompanied by almost no research identifying how to make these same treatments effective when delivered in usual settings of care … when administered by service providers without specialized education in the therapy. (p. 350)

A specialized area known as translational research looks at applying evidence to clinical or bedside practice.

Effective research is best reported in language that is understandable and free of unnecessary jargon:

- Simpler is better.
- Focus on what readers need to know.
- Reduce possible misinterpretations.

Despite the complexities and concerns that must be addressed when implementing best practice, evidence-based nursing is a standard and essential component of nursing practice.

To help the reader understand how best evidence is identified and applied to nursing interventions, this textbook contains a feature box titled **Applying Evidence-Based Practice.** It is hoped that this feature, presented in each of the clinical chapters, will underscore the importance of sound scientific inquiry and ignite the reader's interest in research.

APPLYING EVIDENCE-BASED PRACTICE (EBP)

Problem

A 63-year-old female patient was discharged from a psychiatric hospital. She was homeless and not enrolled in insurance or outpatient mental health services. The message number in the electronic health record (EHR) was no longer valid, so follow-up appointments were not scheduled. A week after discharge, the patient's medication was stolen, and she became suicidal and confused and called the crisis line at her community mental health clinic.

EBP Assessment

A. **What do you already know from experience?** Homeless patients have limited contact information and multiple health concerns.
B. **What does the literature say?** Some of the reasons cited for not attending follow-up appointments are illness, inadequate transportation, forgetting the appointment, and not feeling engaged with providers. Nurses can advocate for patients by addressing gaps in care.
C. **What does the patient want?** The patient wanted her medications and assistance with obtaining resources.

Plan

The crisis team assisted the patient in obtaining medications, finding transportation to a shelter, and enrolling in outpatient mental health services. The nurse practitioner (NP) developed a demographic page in the EHR designed to capture complex contact information for homeless patients, such as where they sleep and eat meals on specific days.

QSEN Prelicensure Knowledge, Skills, and Attitudes (KSAs) Addressed

Safety by minimizing the patient's risk through individual and system performance

Informatics by using technology to manage patient information and prevent error

From Batscha, C., McDevitt, J., Weiden, P., et al. (2011). The effect of an inpatient transition intervention on attendance at the first appointment post-discharge from a psychiatric hospitalization. *Journal of the American Psychiatric Nurses Association, 17*(5), 330–337; Cronenwett, L., Sherwood, G., Barnsteiner, J., et al. (2007). Quality and safety education for nurses. *Nursing Outlook, 55*(3), 122–131; Lamb, V., & Joels, C. (2014). Improving access to health care for homeless people. *Nursing Standard, 29*(6), 45–51; and National Healthcare for the Homeless Council. (2014). *Health reform & homelessness: Twelve key advocacy areas for the HCH community.* Retrieved from http://www.nhchc.org/wp-content/uploads/2011/10/2014-health-reform-policy-statement.pdf

Recovery Model

The mental health **recovery model** is more of a social model of disability than a medical model of disability. Therefore, the focus shifts from one of illness and disease to an emphasis on rehabilitation and recovery. The recovery model is focused on helping individuals develop the knowledge, attitudes, and skills they need to make good choices or change harmful behaviors (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017). The underlying principle is that people can recover from mental illness and substance abuse to lead full, satisfying lives.

The recovery model originated from the 12-step program of Alcoholics Anonymous and a grassroots advocacy initiative called the consumer/survivor/ex-patient movement during the 1980s and 1990s. It is now one of the leading models promoted by SAMHSA (2017). The concept of recovery refers primarily to managing symptoms, reducing psychosocial disability, and improving role performance (SAMHSA, 2017). Holistic interventions, such as encouraging supportive relationships, are designed to promote recovery, as evidenced by functioning in work, engagement in community/social life, and a reduction of symptoms (SAMHSA, 2017). Empowering patients to realize their full potential and independence within the limitations of their illness is the main goal of this model. Recovering from a mental illness is viewed as a personal journey of healing.

The focus of the recovery model has the following mandates (Jacob, 2015):

- Mental health care is to be consumer and family driven, with patients being partners in all aspects of care.
- Care must focus on increasing consumer success in coping with life's challenges and building resilience, not just managing symptoms.
- An individualized care plan is to be at the core of consumer-centered recovery.

Trauma-Informed Care

Another model that is gaining momentum is **trauma-informed care**, a framework developed by the National Center for Trauma-Informed Care (NCTIC), a division of SAMHSA. Trauma-informed care recognizes that trauma is almost universally found in the histories of mental health patients and is a contributor to mental health issues, substance abuse, chronic health conditions, and contact with the criminal justice system. Trauma occurs in many forms, including physical, sexual, and emotional abuse; war; natural disasters; and other harmful experiences. Trauma-informed care provides guidelines for integrating an understanding of how trauma affects patients into clinical programming. A main concept of this approach is a change in paradigm from one that asks, "What's wrong with you?" to one that asks, "What has happened to you?" Key principles also include avoiding retraumatizing through restraints or coercive practices, an open and collaborative relationship between the patient and provider, empowerment, and cultural respect.

The ANA (2015), Institute of Medicine (IOM, 2006, 2011), and QSEN (2020) all support patient-centered care as best practice. Nurses are increasingly expected to understand and synthesize best practice from the literature, care models and theories, neurobiology of psychiatric disorders and medications, and other professional domains into clinical practice.

Quality and Safety Education for Nurses

There is a national initiative toward patient safety and quality, known as QSEN. The overall goal of QSEN is to prepare future nurses who will have the knowledge, skills, and attitudes (KSAs) necessary to continuously improve the quality and safety of the health care systems in which they work (QSEN, 2020). QSEN defines KSAs in each of the following six standards:

- Patient-centered care
- Teamwork and collaboration
- Evidence-based practice
- Quality improvement
- Safety
- Informatics.

Relevant standards or KSAs are referenced in the **Applying Evidence-Based Practice** boxes in the clinical chapters and woven throughout the text.

CONCEPT-BASED NURSING EDUCATION

A major trend in education in the United States, especially nursing education, is the move toward conceptual learning (Giddens, 2017). This move is encouraged and endorsed by major academic institutions, including the IOM, the National League for Nursing (NLN), the American Association of Colleges of Nursing, and the Carnegie Foundation. "Instead of the traditional method of learning which concentrates on the ability to recall specific facts in isolation, concept-based learning concentrates on the understanding of broader principles (concepts) that can be applied to a variety of specific examples" (Lippincott Nursing Education, 2017).

According to Elsevier (2018), the following are some benefits of a concept-based curriculum:

- Encourages students to think at more elevated levels
- Facilitates collaborative and active learning
- Helps streamline content
- Focuses on problems across disease categories and populations
- Supports systematic observations of events or conditions that influence a problem
- Underscores the relationships among events or conditions that impact a situation
- Emphasizes nursing actions and interdisciplinary efforts
- Meets the needs of diverse learners
- Causes higher levels of retention.

The Art of Nursing

Contemporary nursing relies on a scientific foundation and critical thinking. However, the art of nursing is equally important in delivering comprehensive and holistic care. Even the best evidence-based guidelines may not encompass the entire complexity of an individual patient, disorder, or situation. As Williams and Garner (2002, p. 8) conclude, "Too great an emphasis on evidence-based medicine oversimplifies the complex and interpersonal nature of clinical care." The arts of intuition, interpersonal skills, and cultural competence are indispensable parts of effective treatment.

The art of nursing can be difficult to measure or even describe. Terms like caring, professionalism, empathy, kindness, compassion, heart, and relationship are often brought up in describing the art of nursing and even the definitions of these terms can be elusive. Consequently, these attributes are often marginalized, undervalued, and demeaned. The arts of nursing are accomplished through the nurse's **therapeutic use of self**—"essentially, a healthcare provider's use of verbal and nonverbal communication, emotional exchange and other aspects of his or her personality to establish a relationship with the patient that promotes cooperation and healing" ("Therapeutic Use of Self," n.d.) that positively affects patient outcomes.

The health care professional uses self-reflection, self-awareness, and self-evaluation as tools for promoting cooperation, healing, and successful outcomes. It has long been noted that the deciding factor in

therapy outcomes is not the theoretical basis of the clinician/nurse but rather the strength of the clinician–patient relationship. The relationship is strengthened when the patient has developed a sense of safety and respect and feels free to share his or her problems (Shea, 2017). Three areas inherent in the art of nursing addressed here are (1) caring, (2) attending, and (3) advocating.

Caring

Caring is a natural, essential, and fundamental aspect of human existence. An early survey by Schoenhofer and colleagues (1998) used a group process method to synthesize what was meant by *caring* to the participants. The following three themes emerged:

1. Caring is evidenced by empathic understanding, actions, and patience on another's behalf.
2. Caring for another through actions, words, and presence leads to happiness and touches the heart.
3. Caring is giving of self while preserving the importance of self.

The caring nurse is first and foremost a competent nurse. Without knowledge and competence, the demonstration of compassion and caring alone is powerless to help those under a nurse's care. Without a base of knowledge and skills, care alone cannot eliminate another person's confusion, grief, or pain, but a response of care can transform fear, pain, and suffering into a tolerable, shared experience (Smith et al., 2013).

Dr. Jean Watson founded the Watson Caring Science Institute. Watson's caring theory has a spiritual and existential underpinning (Watson Caring Science Institute, 2015). The theory integrates 10 *caritas* (loving principles) that encourage altruism, loving kindness toward self and others, faith and hope, honor, nurturing individual beliefs, helping and trusting relationships, accepting feelings while authentically listening, creative scientific problem solving, teaching and learning using individual styles, physical and spiritual healing environment, assisting with basic human needs, and openness to mystery and miracles.

Comforting as a part of caring includes providing social, emotional, physical, and spiritual support for a patient consistent with holistic nursing care. The provision of comfort measures can be lifesaving and is a basic component of good care. Economic strain and nursing shortages are barriers to the practice of caring and comforting because nurses are burdened with greater workloads and higher-acuity patients. However, caring is both an attitude that one communicates (a way of being with a patient) and also a set of skills that can be learned and developed. Listening to patients takes time, but with practice and experience, nurses can develop the ability to attend to emotional and spiritual needs and get to know their patients while completing an assessment or other tasks.

Attending

Attending refers to an *intensity of presence,* being there for and in tune with the patient. The experience of emotional or physical suffering can be isolating. When a nurse is present and attentive, the feeling of isolation can be reduced. Being present is a practice of awareness, attention, and an intention to understand and connect and goes beyond acts of basic care. It can be shown through body language, posture, touch, reflective listening and eye contact (Gibson, 2020). It is through effective communication that we can fully understand another person's immediate experience, fears, perceptions, and concerns. Attending behaviors are learned and are inherent in a true therapeutic relationship. Chapter 9 discusses attending behaviors in more detail within the context of the nurse–patient relationship.

Advocating

Advocacy in nursing includes a commitment to patients' health, well-being, and safety across their life span; the alleviation of suffering; and the promotion of a peaceful, comfortable, and dignified death (ANA, 2017).

Patient advocacy can occur on many levels, including providing direct patient care; pleading for a course of action; and supporting change in institutional, global, and legislative arenas. The following are examples of patient advocacy activities:

- Providing informed consent, including refusal of treatment
- Respecting patient decisions, even those with which we disagree
- Protecting against threats to well-being
- Being informed about best practices.

These are especially critical when patients lack the knowledge, skills, or ability to speak for themselves.

Patients are afforded protection through providing privacy and confidentiality during participation in research, using standards and reviews, and taking action against questionable or impaired practice.

Lawyers are often viewed as advocates for their clients; however, in nursing, being a **patient advocate** is not a legal role but rather an ethical one. Ethics is an integral part of the foundation of nursing; refer to Chapter 6. The term *patient advocate* was first placed in the 1976 ANA *Code of Ethics for Nurses,* revision, and remains essentially unchanged up to the present. It reads:

> *The nurse must be alert to and take appropriate action regarding any instances of incompetent, unethical, illegal, or impaired practices(s) by any member of the health team or the health care system itself, or any action on the part of others that places the rights or best interest of the patient in jeopardy. (ANA, 2015, 3.5)*

It can take a great deal of courage to advocate for patients when we witness behaviors or actions of health care professionals that could have serious consequences.

Advocating demonstrates respect and value for human life while saving lives or bringing comfort to those who are dying. Psychiatric-mental health nurses also function as advocates when they engage in-public speaking, write articles, and lobby congressional representatives to help improve and expand mental health care (ANA, 2017). Throughout the text, a special feature titled **Applying the Art** gives the reader a glimpse of a nurse–patient interaction and the nurse's thought processes while attending to the patient's concerns.

KEY POINTS TO REMEMBER

- Nursing integrates both scientific knowledge and caring arts into a holistic practice.
- Evidence-based practice (EBP) is a process by which the best available research evidence, clinical expertise, and patient preferences are synthesized while making clinical decisions.
- The 5 A's process of integrating best evidence into clinical practice includes (1) asking, (2) acquiring, (3) appraising, (4) applying, and (5) assessing.
- Application of the recovery model assists people with psychiatric disabilities in effectively managing symptoms, reducing psychosocial disability, and finding a meaningful life in a community of their choosing.
- Trauma-informed care recognizes that various traumas contribute to mental illness and substance abuse. Awareness of trauma can assist health care providers in giving appropriate care and avoiding retraumatization of patients.
- Some sources for obtaining research findings are (1) Internet resources, (2) clinical practice guidelines, (3) clinical algorithms, and (4) clinical/critical pathways.
- The art of nursing is accomplished through the *therapeutic use of self.*
- Three specific areas are inherent within the art of nursing: (1) caring, (2) attending, and (3) advocating.

APPLYING CRITICAL JUDGMENT

1. A friend of yours has recently returned from military service. You are startled when you encounter him on the street in a disheveled state. He appears frightened, seems to be talking to himself, and jumps when a car backfires nearby. You are astounded because there is such a change in his demeanor from the last time you saw him. When you approach him, he seems wary and guarded.
   - **A.** How would the contribution of evidence-based practice (EBP) be helpful to learn about your friend's symptoms of posttraumatic stress disorder (PTSD)?
   - **B.** What might be some specific needs that could be met under the recovery model?
   - **C.** What insight could the trauma-informed care model provide into what your friend is experiencing?
   - **D.** Discuss how nurses can incorporate EBP and care models in their practice.
2. A friend of yours says that he heard about a new practitioner in the area who is going to teach individuals with alcohol dependence how to safely drink in moderation. You state that from all you have read, and from what you know from your friends' experiences, controlled drinking is not thought to be an acceptable practice. Your friend contends that the practitioner has stories and testimonials from individuals with alcohol dependence who are able to drink in a controlled manner. You tell him that there is no strong evidence for this practice.
   - **A.** How would you, as a nurse, evaluate this claim? Explain the five steps you would take to determine the strength of this claim.
   - **B.** Using Table 1.1, what would you say about the quality of the evidence given?
   - **C.** If your friend was in recovery and thinking of trying this treatment, what would you say that would make a strong argument against such a decision?
3. You are a new nursing student, and a friend of yours says, "What on earth is the 'art of nursing'? Isn't that some weird new-age stuff?"
   - **A.** Discuss three components that are inherent in the art of nursing.
   - **B.** Explain the concept of the therapeutic use of self in applying the art of nursing.
   - **C.** Give your friend an example of how nurses demonstrate comfort or caring in the clinical area.
   - **D.** Explain why patients need to have nurses act as their advocate. Can you think of an example from your clinical experience?
4. Go to the Centre for Evidence-Based Mental Health at http://www.cebmh.com and review at least one available clinical trial.

CHAPTER REVIEW QUESTIONS

1. In which scenario is it most urgent for the nurse to act as a patient advocate?
   - **a.** An adult cries and experiences anxiety after a near-miss automobile accident on the way to work.
   - **b.** A homeless adult diagnosed with schizophrenia lives in a community expecting a category 5 hurricane.
   - **c.** A 14-year-old girl's grades decline because she consistently focuses on her appearance and social networking.
   - **d.** The parents allow the prescription to lapse for 1 day for their 8-year-old child's medication for attention-deficit/hyperactivity disorder.
2. The nurse interacts with a veteran of World War II. The veteran says, "Veterans of modern wars whine and complain all the time. Back when I was in service, you kept your feelings to yourself." Select the nurse's best response.
   - **a.** "American society in the 1940s expected World War II soldiers to be strong."
   - **b.** "World War II was fought in a traditional way, but the enemy is more difficult to identify in today's wars."
   - **c.** "We now have a better understanding of how trauma affects people and the importance of research-based, compassionate care."
   - **d.** "Intermittent explosive devices (IEDs), which were not in use during World War II, produce traumatic brain injuries that must be treated."
3. A patient reports sleeplessness, fatigue, and sadness to the primary care provider. In our current health care climate, what is the most likely treatment approach that will be offered to the patient?
   - **a.** Group therapy
   - **b.** Individual psychotherapy
   - **c.** Complementary therapy
   - **d.** Psychopharmacological treatment
4. The nurse prepares outcomes to the plan of care for an adult diagnosed with mental illness. Which strategy recognizes the current focus of treatment services for this population?
   - **a.** The patient's diagnoses are confirmed using advanced neuroimaging techniques.
   - **b.** The nurse confers with the treatment team to verify the patient's most significant disability.

c. The nurse prioritizes the patient's problems in accordance with Maslow's hierarchy of needs.
d. The patient and family participate actively in establishing priorities and selecting interventions.

5. Which scenario best demonstrates empathic caring?
a. A nurse provides comfort to a colleague after an error of medication administration.
b. A nurse works a fourth extra shift in 1 week to maintain adequate unit staffing.
c. A nurse identifies a violation of confidentiality and makes a report to an agency's privacy officer.
d. A nurse conscientiously reads current literature to stay aware of new evidence-based practices.

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