Prior to coming to clinical (inpatient psychiatric unit or Mental Health Clinic) read the case study about Betty and answer the questions. In the clinical setting observe a client with Generalized Anxiety Disorder and the manifestations of that client. Research how the client is being managed and compare and contrast that with Betty’s case. If at an inpatient facility, discuss the indications for why a client with GAD would require inpatient care rather than outpatient therapy. Does the client have coexisting medical or psychiatric conditions? If so, is there a relationship between the coexisting conditions? Discuss the potential interactions between GAD and depression in terms of treatment. Discuss the impact on seeking psychiatric care, treatment, and health maintenance for other cultural groups including the native American and asian American. Compare the findings discussed in the case study concerning Betty. What is the nurse’s role as a member of the interdisciplinary team when caring for a client with GAD? This can be an individual student assignment or students may be divided into small groups. The findings may be presented in post-conference or class or may be a written assignment.

Additional cases provide the opportunity to address a wide variety of psychiatric conditions and the standards of care for these conditions. The focus of the care studies is to stimulate critical thinking on the part of the reader. Understanding the nursing implications and why these are so important to the health and welfare of clients is a thread throughout the case studies as well as the depth of knowledge nurses must have related to pharmacological and adjunctive therapies used in the treatment of psychiatric conditions.
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Preface

Thomson Delmar Learning’s Case Studies Series was created to encourage nurses to bridge the gap between content knowledge and clinical application. The products within the series represent the most innovative and comprehensive approach to nursing case studies ever developed. Each title has been authored by experienced nurse educators and clinicians who understand the complexity of nursing practice as well as the challenges of teaching and learning. All of the cases are based on real-life clinical scenarios and demand thought and “action” from the nurse. Each case brings the user into the clinical setting, and invites him or her to utilize the nursing process while considering all of the variables that influence the client’s condition and the care to be provided. Each case also represents a unique set of variables, to offer a breadth of learning experiences and to capture the reality of nursing practice. To gauge the progression of a user’s knowledge and critical thinking ability, the cases have been categorized by difficulty level. Every section begins with basic cases and proceeds to more advanced scenarios, thereby presenting opportunities for learning and practice for both students and professionals.

All of the cases have been expert reviewed to ensure that as many variables as possible are represented in a truly realistic manner and that each case reflects consistency with realities of modern nursing practice.

Praise for Delmar, Cengage Learning’s Case Study Series

“These cases show diversity and richness of content and should stimulate lively discussions with students.”

—LINDA STAFFORD, PhD, RN
Division Head, Psychiatric Mental Health Nursing, School of Nursing, The University of Texas Health Science Center at Houston

“The use of case studies is pedagogically sound and very appealing to students and instructors. I think that some instructors avoid them because of the challenge of case development. You have provided the material for them.”

—NANCY L. OLDENBURG, RN, MS, CPNP
Clinical Instructor, Northern Illinois University

“[The author] has done an excellent job of assisting students to engage in critical thinking. I am very impressed with the cases, questions, and content. I rarely ask that students buy more than one . . . book . . . but, in this instance, I can’t wait until this book is published.”

—DEBORAH J. PERSELL, MSN, RN, CPNP
Assistant Professor, Arkansas State University
“[The case studies] are very current and prepare students for the twenty-first-century mental health arena.”

—CHARLOTTE R. PRICE, EdD, RN  
Professor and Chair, Augusta State University  
Department of Nursing

“One thing I always tell my students is that they will encounter mental health issues in all the various areas of nursing that they practice. Often they don’t grasp this concept. . . . Many mental health nursing books focus on mental health settings and miss the other settings. I appreciate the fact that different settings were used in this reading . . . inpatient and outpatient, as well as med-surg, plastic surgery, etc.”

—KIMBERLY M. GREGG, MS APRN, BC  
Adult Mental Health Clinical Nurse Specialist,  
Altru Health Systems, Instructor, University of North Dakota

“This is a groundbreaking book. . . . This book should be a required text for all undergraduate and graduate nursing programs and should be well-received by faculty.”

—JANE H. BARNSTEINER, PhD, RN, FAAN  
Professor of Pediatric Nursing, University of Pennsylvania School of Nursing

How to Use this Book

Every case begins with a table of variables that are encountered in practice, and that must be understood by the nurse in order to provide appropriate care to the client. Categories of variables include age, gender, setting, ethnicity, cultural considerations, preexisting conditions, coexisting conditions, communication considerations, disability considerations, socioeconomic considerations, spiritual considerations, pharmacological considerations, psychosocial considerations, legal considerations, ethical considerations, alternative therapy, prioritization considerations, and delegation considerations. If a case involves a variable that is considered to have a significant impact on care, the specific variable is included in the table. This allows the user an “at a glance” view of the issues that will need to be considered to provide care to the client in the scenario. The table of variables is followed by a presentation of the case, including the history of the client, current condition, clinical setting, and professionals involved. A series of questions follows each case that ask the user to consider how she would handle the issues presented within the scenario. Suggested answers and rationales are provided for remediation and discussion.

Organization

Cases are grouped according to psychiatric disorder. Within each part, cases are organized by difficulty level from easy, to moderate, to difficult. This classification is somewhat subjective, but they are based upon a developed standard. In general, difficulty level has been determined by the number of variables that impact the case and the complexity of the client’s condition. Colored tabs are used to allow the user to distinguish the difficulty levels more easily. A comprehensive table of variables
is also provided for reference, to allow the user to quickly select cases containing a particular variable of care.

The cases are fictitious; however, they are based on actual problems and/or situations the nurse will encounter. Any resemblance to actual cases or individuals is coincidental.

Acknowledgments

For the invitation to write this book, the author wishes to express her appreciation to Erin Silk and Matt Kane of Thomson Delmar Publishers. A number of product managers and staff were involved over time, and the author thanks them for their help. The author is most indebted to Elizabeth (Libby) Howe, the final product manager, who provided guidance, feedback, ideas, and encouragement to keep the project alive and get the book into print. Another special thanks goes to Nora Armbruster, who managed the final production stage and made it possible to meet the print deadline. The author wants to especially thank the reviewers and copy editors of this book, for their time, expertise, critical comments, and suggestions, which resulted in changes to make the book much better.

A number of colleagues at Austin Community College, Austin, Texas; Austin State Hospital; and Seton Shoal Creek Psychiatric Hospital, as well as other psychiatric and medical facilities, were consulted about selected aspects of the cases to verify accuracy and currency. The author recognizes and appreciates the important contributions of these colleagues: Sally Samford, Marita Peppard, Donna Edwards, Kris Benton, Kitty Viek, Jane Luetchens, and many others.

Teachers and school nurses were consulted, as were parents of children with special issues. The author wishes to recognize their important contributions, especially Edna Nation, who teaches high school students in Liberty Hill, Texas, for her dedication to helping all students—including those with medical and mental health problems—achieve their maximum potential and for sharing her ideas with the author.

The author thanks her family and friends for their patience and understanding during the long months of research and writing. This project could not have been finished without their encouragement and cooperation.

Dedication

This book is dedicated to my son Mark, who has battled cancer throughout most of the time this book was in progress. Sharing with me some of his innermost thoughts, fears, and struggles has reinforced for me that what student nurses, family, and others see on the surface in a brief interaction with a client can be a very different picture than what is going on inside the client. Compassion, empathy, and therapeutic communication do help us understand that inner person. I am indebted to Mark for all he has taught me.

Additionally, this book is dedicated to all the good nurses in various fields of nursing, not just psychiatric mental health nursing, who apply psychiatric techniques and principles when working with clients who have mental health diagnoses and/or issues.

Note from the Author

These case studies were designed to help nursing students at all levels to not only fine tune their critical thinking skills and their therapeutic communication skills, but to develop a deeper understanding of, and empathy for, clients who have what
we currently refer to as psychiatric problems. The mind and body are inseparable, so physical health problems are interwoven with mental health problems within the cases. The student nurse, and anyone else who reads these case studies, is encouraged to ask themselves: “What is the most therapeutic approach or response to this client in this situation?” as they answer the questions within the cases.

About the Author

Dr. Richardson began a nursing career in 1959 as a new diploma graduate. She worked five years in obstetrical nursing at Memorial Medical Center, Springfield, Illinois; much of this time she worked in the labor rooms and applied nearly everything she learned in psychiatric nursing to emotionally support laboring women, new mothers, and grieving parents who lost babies. She next worked as an office nurse for Dr. Tom Masters, a general internist who specialized in Diabetes. The following several years she worked for the Illinois Department of Mental Health Mental Retardation, working on an outpatient team serving three rural counties. The team followed the blurred role concept in which every member did intake evaluations and did counseling with people having the full range of diagnoses and issues possible in mental health work. This work stimulated a return to school for a bachelor’s in nursing and a master’s in administration from the University of Illinois at Springfield, a master’s degrees in adult nursing from the Medical College of Georgia, and a PhD in psychiatric mental health nursing from the University of Texas at Austin, Texas. Her dissertation was “The Psychiatric Inpatient’s Perception of the Seclusion Room Experience.” She published the results of this study in Nursing Research. Dr. Richardson has taught in an RN to BSN program, two ADN programs, and a licensed vocational nursing program. She received the NISOD teaching award for teaching excellence from the University of Texas.

Throughout the years, volunteer work has been a passion. Dr. Richardson made fifteen trips to Honduras and Nicaragua with MEDICO, a nonprofit organization taking medical, eye, and dental care to remote areas that are medically underserved. She co-led trips to the Moskito Coast of Nicaragua and Honduras and volunteered for several months in a program to take boys off the streets of LaCeiba, Honduras. Additional volunteer work has been with the homeless in Austin, Texas.

Dr. Richardson is also a licensed professional counselor and a licensed marriage and family therapist and has done therapy for over thirty years (full time and part time). She has worked as a therapist in a residential program for children and adolescents and as a service administrator and therapist on a child/adolescent unit in a private psychiatric hospital. She led weekend groups in a private psychiatric hospital for many years while teaching full time. She was Director of Nursing of Austin State Hospital, Austin, Texas, for six years. Over the years, Dr. Richardson has had training with a number of the great theorists such as Bettleheim, Azrin, Frankl, Ellis, and others. She has had training in a variety of therapies from Psychoanalytic Theory to Play Therapy to Brief Psychotherapy. She is a board-certified clinical specialist in child adolescent psychiatric nursing (certified by the American Nurses Association). She continues in her private practice, works part time in a drug study clinic, freelances for publishers, and has written a monthly column for parents in the newsmagazine Austin Parent since 1992. Dr. Richardson has lived in Austin, Texas, for over twenty-five years, and she can be contacted there by e-mail at bkrich@sbcglobal.net.
Comprehensive Table of Variables
## Comprehensive Table of Variables

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**CASE STUDY 2**

**Betty**

**GENERALIZED ANXIETY DISORDER**

**Level of difficulty:** Moderate

**Overview:** Requires critical thinking to understand and manage the common Hispanic practice of extended family being with a client for health care visits. The nurse must also identify behaviors common in clients with a diagnosis of Generalized Anxiety Disorder (GAD) and become knowledgeable about treatment modalities, including the antidepressant BuSpar.

| GENDER | Female |
| AGE | 50 |
| SETTING | Community mental health center |
| ETHNICITY | Mexican American |
| CULTURAL CONSIDERATIONS | Hispanic |
| PREEXISTING CONDITION |  |
| COEXISTING CONDITION |  |
| COMMUNICATION |  |
| DISABILITY |  |
| SOCIOECONOMIC | Daughter of migrant farmers; currently middle class |
| SPIRITUAL/RELIGIOUS |  |
| PHARMACOLOGIC | Calcium, Vitamins, Hormone replacement, Buspirone (BuSpar) |
| PSYCHOSOCIAL | Impaired social isolation |
| LEGAL |  |
| ETHICAL |  |
| ALTERNATIVE THERAPY | Herbal treatments containing Kava and Passaflora obtained from a curandera |
| PRIORITIZATION |  |
| DELEGATION |  |
**Case Studies**  
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**Sample Case Study**

### Client Profile

**Betty**, a 50-year-old woman, came to this country with her parents when she was 7 years old. The family members worked as migrant farm workers until they had enough money to open a restaurant. Betty married young. She and her husband worked in the family restaurant and eventually bought it from the parents. They raised seven children, all grown and living on their own. Betty and her husband live in a mobile home close to the restaurant. She does not work in the family restaurant anymore because she worries excessively about doing a poor job. Betty no longer goes out if she can help it. She stays at home worrying about how she looks, what people think or say, the weather or road conditions, and many other things. Betty is not sleeping at night and keeps her husband awake when she roams the house. She keeps her clothing and belongings in perfect order while claiming she is doing a poor job of it. She does not prepare large family dinners anymore, though she still cooks the daily meals; one daughter has taken over the family dinners. This daughter has become concerned about Betty being isolated at home and worrying excessively and calls the community mental health center for an appointment for Betty.

### Case Study

Betty presents at the community mental health center accompanied by her husband, her children and their spouses, several grandchildren, and a few cousins. When Betty’s name is called and she is told that the nurse is ready to see her, she frowns and says: “What will I say? I don’t know what to say. I think my slip is showing. My hem isn’t straight.”

Betty says she wants her whole family to go in to see the nurse with her. The nurse notices that Betty is extremely well groomed and dressed in spite of concerns she has been voicing about her appearance. Before the psychiatric nurse interviews Betty alone, she hears from the daughter that Betty “worries all the time” and although she has always been known to be a worrier, the worrying has become worse over the past six or eight months. The husband shares that his wife is keeping him awake at night with her inability to get to sleep or stay asleep.

The nurse interviews Betty alone. The nurse notices that Betty casts her eyes downward, speaks in a soft voice, does not smile, and seems restless as she taps her foot on the floor, drums her fingers on the table, and seems on the verge of getting out of her chair. Themes in the interview include: being tired, getting tired easily, not being able to concentrate, not getting work done, trouble sleeping, worrying about whether her husband loves her anymore and whether she and her husband have enough money, and not having the energy to attend to the housework or her clothing.

The nurse has the impression that Betty’s anxiety floats from one worry to another. There is no convincing Betty that she looks all right. Any attempt to convince her that she need not worry about something in particular leads to a different worry before coming back to the earlier worry.

The community mental health psychiatrist examines Betty and, after a thorough physical examination and lab studies, finds nothing to explain her fatigue and difficulty sleeping other than anxiety. Betty produces her medicine bottles and says she is currently taking only vitamins, hormone replacement, and calcium. The psychiatrist asks the nurse to contact Betty’s family health care provider to get information on any medical or psychiatric conditions he is treating her for; the report comes back that she has no medical diagnoses and the family health care provider thinks she suffers from anxiety. The psychiatrist prescribes buspirone (BuSpar) for Betty.
Two weeks later, during a home visit to Betty, the nurse learns, with some probing, that Betty is upset with her husband for loaning all their savings to the daughter and her husband to build a new home, while they continue to live in an older mobile home. At the end of the nurse’s home visit, Betty’s daughter arrives and tells the nurse that she wonders if Betty is making any progress. Betty also worries she is not getting better and asks the nurse about taking some herbal medicines containing Kava and Passaflora that her sister got from a curandara (folk healer); her sister wants to take her to see the curandara and have her do a ritual to cure the evil eye that was placed on Betty and made her sick.

Questions

1. What behaviors does this client have that match the criteria for a diagnosis of Generalized Anxiety Disorder?

2. How common is the diagnosis of Generalized Anxiety Disorder? Is it common for clients with GAD to have comorbidity, and should this client be assessed for any particular condition?

3. What explanation do you have for the number of family members coming to the community mental health center with this client? If you were the nurse, how would you deal with Betty’s request for her whole family to accompany her to see you?

4. Before the nurse, or any other staff at the community mental health center, can talk with Betty’s family health care provider, what do they need to do?

5. What does the nurse need to know about buspirone? What teaching needs to be done with the client in regard to buspirone? What medications other than buspirone are being used in the treatment of GAD, and how effective are they?

6. What are some of the interventions, in addition to antianxiety drugs, that are being used with clients who have GAD?

7. At one point the daughter says that she thinks Betty is not showing progress. What progress, if any, do you think has been made? What can you tell the daughter?

8. What do you think about Betty’s sister using herbal remedies and rituals for driving out evil spirits in trying to cure Betty? Do herbal remedies work?

9. What nursing diagnoses would you write for Betty related to her Generalized Anxiety Disorder?
Questions and Suggested Answers

1. What behaviors does this client have that match the criteria for a diagnosis of Generalized Anxiety Disorder?
   In order to meet the criteria for a diagnosis of Generalized Anxiety Disorder (GAD), a person must have “excessive anxiety and worry” and “apprehensive expectation” occurring on more days than it does not occur for at least six months and involving a variety of worries about various events or activities. The person has to find it difficult to control the anxiety and worry. In addition, the person must have at least three other symptoms from a list including restlessness, fatiguing easily, concentration difficulties, irritability, muscle tension, and sleep problems, which include difficulty getting asleep, difficulty staying asleep, or feeling as if the sleep has not satisfied their needs (APA, 2000). Betty has had excessive worry most days for over six months. The nurse observed this client’s restless behavior and heard her complaints of fatigue. The client’s husband described her failure to sleep at night.

   In addition to the criteria already mentioned, the person diagnosed as having GAD must experience significant distress or impairment in some area of functioning, such as social or occupational, as a result of the anxiety, worry, or physical symptoms. Betty has experienced impairment in both social and occupational areas of her life as a result of her anxiety and worry.

2. How common is the diagnosis of Generalized Anxiety Disorder? Is it common for clients with GAD to have comorbidity, and should this client be assessed for any particular condition?
   According to Mason and Jacobson (1999), Generalized Anxiety will affect one in twenty adults sometime during their lives and most of those affected will be women. This is congruent with the DSM IV-TR statement that the lifetime prevalence rate of GAD was 5 percent based on a community sample.

   A large percentage of people with GAD are believed to have a comorbid diagnosis. Wells (1999) describes one national comorbid survey that found more than 90 percent of those with a diagnosis of GAD had a comorbid diagnosis, with 22 percent experiencing dysthymia and 39–69 percent experiencing depression. This client needs to be screened for symptoms of mood disorders.

3. What explanation do you have for the number of family members coming to the community mental health center with this client? If you were the nurse, how would you deal with Betty’s request for her whole family to accompany her to see you?
   Hispanic and Hispanic Americans are often part of a large extended family system. It is not unusual for extended family members to accompany a Hispanic or Hispanic American person to the office of health care providers or to a health care facility.

   You need to build some rapport with the family, and this involves respecting the family and their culture, acknowledging each family member, and accepting any input given voluntarily from family members. When the client has medical problems, the nurse can perform most if not all procedures with family members present. When the client has mental health problems, it is important to observe interactions with others, but it is also exceedingly important to talk with the client alone so the client’s issues can be explored in a therapeutic environment with a professional and without the distraction of family members.

4. Before the nurse, or any other staff at the community mental health center, can talk with Betty’s family health care provider, what do they need to do?
   Before talking with the family health care provider about Betty’s case, the nurse needs to get a release of information form signed by Betty.

5. What does the nurse need to know about buspirone? What teaching needs to be done with the client in regard to buspirone? What medications other than buspirone are being used in the treatment of GAD, and how effective are they?
   The nurse needs to know the following information about buspirone:
   - It binds to serotonin and dopamine receptors increases norepinephrine metabolism in the brain.
   - It is contraindicated in hypersensitivity and severe hepatic or renal impairment.
   - Usual dose is 20–30 mg/day and is not to exceed 60mg/day.
   - Concurrent use with itraconazole or erythromycin increases blood levels and dosage reduction may need to occur if using these drugs.
Part 2 ■ THE CLIENT EXPERIENCING ANXIETY

- Patients changing from other antianxiety drugs to BuSpar should be gradually tapered off their other antianxiety meds before being placed on BuSpar.
- While some improvement may occur in seven to ten days, optimal improvement takes three to four weeks.

Teaching about buspirone needs to include the following information:

- Buspirone is given for the management of anxiety.
- It must be taken exactly as directed.
- Although food slows absorption, this drug may be taken with food to decrease gastric irritation. It needs to be taken either consistently with or consistently without food.
- Alcohol and other CNS depressants are not to be concurrently used.
- Client should consult health care provider before taken any over-the-counter drugs.
- Client should notify health care provider if any abnormal movements noticed while on this drug.
- Side effects can include dizziness and drowsiness so client shouldn’t drive until he or she knows the medication is not going to cause these side effects.
- Client should keep follow-up appointments to evaluate effectiveness of medication (Spratto and Woods, 2006).

In addition to buspirone, venlafaxine extended release therapy (Effexor XR) has been found to be effective in treating the symptoms of Generalized Anxiety Disorder (Rose, 1998). Imipramine, opipramol, paroxetine, and trazodone have also been found to improve symptoms over four to eight weeks (Newman, Consoli, and Andres, 1999).

6. What are some of the interventions, in addition to antianxiety drugs, that are being used with clients who have GAD? Cognitive Behavioral Therapy is one of a number of treatment modalities used today with patients who have a diagnosis of GAD. Wells (1999) describes a model in which generalized anxiety is an abnormal state of worrying involving worry about worrying. In the therapy, worry is used as a strategy to control worry and put it to work.

   Newman and Consoli (1999) report a palmtop computer program that can be used to increase the efficiency of Cognitive Behavioral Therapy in working with clients with GAD. The program, as they describe it, assists in ongoing unobtrusive gathering of data about treatment adherence and the impact of the therapy techniques. The computer draws the treatment out beyond the hour with the therapists and motivates clients to do homework assignments by “prompting practice of cognitive behavioral strategies.”

7. At one point the daughter says that she thinks Betty is not showing progress. What progress, if any, do you think has been made? What can you tell the daughter? The client has made some progress in the area of “trust” and developing trusting relationships. Betty confided her feelings and thoughts about the husband loaning money to the daughter. You can tell the daughter that the medication Betty is taking has a slow onset of action: it tends to require at least two weeks to show benefits and longer for maximum benefit. Frisch and Frisch (2006) point out that the effect of buspirone is delayed, often as much as seven weeks, but it can be as effective as benzodiazepines in controlling anxiety/worry without the abuse potential of benzodiazepines.

8. What do you think about Betty’s sister using herbal remedies and rituals for driving out evil spirits in trying to cure Betty? Do herbal remedies work? Many herbal remedies do produce some beneficial effects, and herbas are used in the development of new medicines; however, the nurse in this case must caution Betty about the possibility of her herbal medication interacting negatively with her prescribed medications, as well as a lack of control on the quality of herbal medicines. The nurse needs to advise her to check with her prescribing health care provider before taking herbals. Kava has been found to have an effect on vagal cardiac control in Generalized Anxiety Disorder (Watkins et al. 2001). According to Akhondzadeh et al. (2001), Passafloara (passionflower) is an old folk remedy for anxiety. Treatment effectiveness of passafloara was compared to that of oxazepam (Serax) in a double-blind randomized trial. While oxazepam results were
seen quicker, this drug produced impairment of job performance whereas passaflora was found to be effective with a much lower incidence of job performance impairment. Rituals to drive out evil spirits may help decrease anxiety for some people. If a person believes strongly enough that a ritual will drive out evil spirits, it could possibly stop the worry or reduce the time spent in worrying.

9. **What nursing diagnoses would you write for Betty related to her Generalized Anxiety Disorder?** Possible nursing diagnoses based on the assessment of Betty’s generalized anxiety include:

- Anxiety
- Impaired social interaction
- Social isolation
- Altered role performance

**References**


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