ADJUSTMENT DISORDERS

DSM-IV

ADJUSTMENT DISORDERS (SPECIFY IF ACUTE/CHRONIC)
309.24 With anxiety
309.0 With depressed mood
309.3 With disturbance of conduct
309.4 With mixed disturbance of emotions and conduct
309.28 With mixed anxiety and depressed mood

The essential feature of adjustment disorders is a maladaptive reaction to an identifiable psychosocial stressor that occurs within 3 months of the onset of the stressor. (The reaction to the death of a loved one is not included here, as it is generally diagnosed as bereavement.) The stressor also does not meet the criteria for any specific Axis I disorder or represent an exacerbation of a preexisting Axis I or Axis II disorder.

The response is considered maladaptive because social or occupational functioning is impaired or because the behaviors are exaggerated beyond the usual expected response to such a stressor. Duration of the symptoms for more than 6 months indicates a chronic state. By definition, an adjustment disorder must resolve within 6 months of the termination of the stressor or its consequences. If the stressor/consequences persist (e.g., a chronic disabling medical condition, emotional difficulties following a divorce, financial reversals resulting from termination of employment, or a developmental event such as leaving one's parental home, retirement), the adjustment disorder may also persist.

ETIOLOGICAL THEORIES

Psychodynamics

Factors implicated in the predisposition to this disorder include unmet dependency needs, fixation in an earlier level of development, and underdeveloped ego.

The client with predisposition to adjustment disorder is seen as having an inability to complete the grieving process in response to a painful life change. The presumed cause of this inability to adapt is believed to be psychic overload—a level of intrapsychic strain exceeding the individual's ability to cope. Normal functioning is disrupted, and psychological or somatic symptoms occur.

Biological

The presence of chronic disorders is thought to limit an individual's general adaptive capacity. The normal process of adaptation to stressful life experiences is impaired, causing increased vulnerability to adjustment disorders. A high family incidence suggests a possible hereditary influence.

The autonomic nervous system discharge that occurs in response to a frightening impulse and/or emotion is mediated by the limbic system, resulting in the peripheral effects of the autonomic nervous system seen in the presence of anxiety.

Some medical conditions have been associated with anxiety and panic disorders, such as abnormalities in the hypothalamic-pituitary-adrenal and hypothalamic-pituitary-thyroid axes; acute myocardial infarction; pheochromocytomas; substance intoxication and withdrawal; hypoglycemia; caffeine intoxication; mitral valve prolapse; and complex partial seizures.

Family Dynamics

The individual's ability to respond to stress is influenced by the role of the primary caregiver (her or his ability to adapt to the infant's needs) and the child-rearing environment (allowing the child gradually to gain independence and control over own life). Difficulty allowing the child to become independent leads to the child having adjustment problems in later life.

Individuals with adjustment difficulties have experienced negative learning through inadequate role-modeling in dysfunctional family systems. These dysfunctional patterns impede the development of self-esteem and adequate coping skills, which also contribute to maladaptive adjustment responses.

CLIENT ASSESSMENT DATA BASE

(Symptoms of affective, depressive, and anxiety disorders are manifested dependent on the individual's specific response to a stressful situation.)

Activity/Rest

Fatigue
Insomnia

Ego Integrity

Reports occurrence of personal stressor/loss (e.g., job, financial, relationship) within past 3 months
May appear depressed and tearful and/or nervous and jittery
Feelings of hopelessness

Neurosensory

Mental Status: Depressed mood, tearful, anxious, nervous, jittery

Attention and memory span may be impaired (depends on presence of depression, level of anxiety, and/or substance use)

Communication and thought patterns may reveal negative ruminations of depressed mood or flight of ideas/loose associations of severely anxious condition

Pain/Discomfort

Various physical symptoms such as headache, backache, other aches and pains (maladaptive response to a stressful situation)

Safety

Anger expressed inappropriately
Involvement in high-risk behaviors (e.g., fighting, reckless driving)
Suicidal ideations may be present

Social Interactions

Difficulties with performance in work/social setting, when no difficulties had been experienced prior to the occurrence of the stressor
Socially withdrawn/refuses to interact with others (e.g., isolates self in own room)
Reports of vandalism, reckless driving, fighting, defaulting on legal responsibilities, violation of the rights of others or age-appropriate norms and rules
May display manipulative behavior (e.g., testing limits, playing individuals/family members against each other)

Teaching/Learning

Academic difficulties, failure to attend class/complete course work
Substance use/abuse possibly present

DIAGNOSTIC STUDIES

Diagnostic studies and psychological testing as indicated to rule out conditions that may mimic or coexist (e.g., endocrine imbalance, cardiac involvement, epilepsy, or a differential diagnosis with affective, anxiety, conduct, or antisocial personality disorders).
Drug Screen: Determine substance use.

NURSING PRIORITIES

1. Provide safe environment/protect client from self-harm.
2. Assist client to identify precipitating stressor.
3. Promote development of effective problem-solving techniques.
4. Provide information and support for necessary lifestyle changes.
5. Promote involvement of client/family in therapy process/planning for the future.

DISCHARGE GOALS

1. Relief from feelings of depression and/or anxiety noted, with suicidal ideation reduced.
2. Anger expressed in an appropriate manner.
3. Maladaptive behaviors recognized and rechanneled into socially accepted actions.
4. Client involved in social situations/interacting with others.
5. Ability and willingness to manage life situations displayed.
6. Plan in place to meet needs after discharge.

NURSING DIAGNOSIS	**ANXIETY [moderate to severe]**
May Be Related to:	Situational/maturational crisis
	Threat to self-concept; threat (or perceived threat) to physical integrity
	Unmet needs; fear of failure
	Dysfunctional family system; unsatisfactory parent/child relationship resulting in feelings of insecurity
	Fixation in earlier level of development
Possibly Evidenced by:	Overexcitement/restlessness; increased tension; insomnia
	Feelings of inadequacy; fear of unspecified consequences
	Poor eye contact, focus on self; difficulty concentrating
	Continuous attention-seeking behaviors; selective inattention
	Sympathetic stimulation; numerous physical complaints

Desired Outcomes/Evaluation Criteria—Client Will:	
	Verbalize awareness of feelings of/indicators of increasing anxiety.
	Demonstrate/use appropriate techniques to interrupt escalation of anxiety.
	Appear relaxed and report anxiety is reduced to a manageable level.

ACTIONS/INTERVENTIONS	RATIONALE
Independent	
Establish a therapeutic nurse/client relationship. Be honest, consistent in responses, and available. Show genuine positive regard.	Honesty, availability, and unconditional acceptance promote trust, which is necessary for the development of a therapeutic relationship.
Provide activities geared toward reduction of tension and decreasing anxiety (e.g., walking or jogging, musical exercises, housekeeping chores, group games/activities).	Tension and anxiety can be released safely, and physical activity may provide emotional benefit to the client through release in the brain of morphine-like substances (endorphins) that promote sense of well-being.
Encourage client to identify true feelings and to acknowledge ownership of those feelings.	Anxious clients often deny a relationship between emotional problems and their anxiety. Use of the defense mechanisms of projection and displacement are exaggerated.
Maintain a calm atmosphere and approach to client.	Can help to limit transmission of anxiety to/from client.
Assist client to recognize specific events that precede onset of elevation in anxiety. Provide information about signs and symptoms of increasing anxiety and ways to intervene before behaviors become disabling.	Recognition of precipitating stressors and a plan of action to follow should they recur provides client with feelings of security and control over similar situations in the future. This in itself may help to control anxiety response.
Offer support during times of elevated anxiety. Provide physical and psychological safety. (Refer to ND: Violence, risk for, directed at self/others.)	Presence of a trusted individual may provide needed security/client safety.
Collaborative	
Administer medications as necessary, e.g., benzodiazepines: alprazolam (Xanax).	Antianxiety medications induce a calming effect and work to maintain anxiety at a manageable level while providing the opportunity for client to develop other ways to manage stress.

NURSING DIAGNOSIS	VIOLENCE, risk for, directed at self/others
Risk Factors May Include:	Depressed mood, hopelessness, powerlessness; inability to tolerate frustration; rage reactions
	Low self-esteem; unmet needs
	Negative role modeling; lack of support systems
	Substance use/abuse; history of previous suicide attempts
[Possible Indicators:]	Increased motor activity (pacing, excitement, irritability, agitation)
	Muscle tension (e.g., clenched fists, tense facial expressions, rigid posture, tautness)
	Hostile, threatening verbalizations; provocative behavior (argumentative, dissatisfied, overreactive, hypersensitive)
	Suicide ideation
Desired Outcomes/Evaluation Criteria—Client Will:	Verbalize understanding of behavior and precipitating factors.
	Participate in care and meet own needs in an assertive manner.
	Rechannel anger/hostile feelings into socially acceptable behaviors.
	Demonstrate self-control as evidenced by relaxed posture, absence of violent behavior, etc.
	Use resources/support systems in an effective manner.

ACTIONS/INTERVENTIONS	RATIONALE
Independent	
Observe client's behavior frequently during routine activities and interactions; avoid appearing watchful and suspicious.	Close observation is required so that intervention can occur if required to ensure the safety of others. Instilling suspicion may provoke aggressive behaviors.
Ask client direct questions regarding intent, plan, and availability of the means for self-harm. Evaluate and prioritize on a scale of 1–10 according to severity of threat, availability of means.	Direct questions, if presented in a caring, concerned manner, provide the necessary information to assist the nurse in formulating an appropriate plan of care for the suicidal client.
Provide a safe environment: reduce stimuli (e.g., low lighting, few people, simple decor, low noise level).	A stimulating environment may increase agitation and provoke aggressive behavior.

Remove potentially dangerous objects, such as straps, belts, ties, sharp objects, glass items, and drugs, as indicated.	External control of environment aids in preventing impulsive actions at a time when client lacks own internal controls.
Secure contract from client that she or he will not harm self and will seek out staff member if suicidal ideations emerge.	A contract encourages the client to share in the responsibility of own safety. A degree of control is experienced, and the attitude of acceptance of the client as a worthwhile individual is conveyed.
Promote verbalizations of honest feelings. Through exploration and discussion, help client identify symbols of hope in own life.	May be difficult for client to express negative feelings. Verbalization of these feelings in a nonthreatening environment may help client come to terms with unresolved issues and identify reasons for wanting to change life/continue living.
Help client identify true source of anger/hostility and underlying feelings.	Because of weak ego development, client may be using the defense mechanism of displacement. Helping the client to recognize this in a nonthreatening environment may help reveal unresolved issues so that they may be confronted, regardless of the discomfort involved.
Convey an attitude of acceptance toward the client. Impart a message that it is not the client but the behavior that is unacceptable. regard.	Promotes feelings of self-worth. These feelings are further enhanced as person and behavior are viewed separately, communicating unconditional positive
Explore with client alternative ways of handling frustration/pent-up anger that channel hostile energy into socially acceptable behavior (e.g., brisk walks, jogging, physical exercises, volleyball, punching bag, exercise bike).	Physically demanding activities help to relieve pent-up tension. **Note:** Exercise need not be aerobic or intensive to achieve therapeutic effect.
Maintain a calm attitude toward the client if behavior escalates. Have sufficient staff available to convey a show of strength to the client if it becomes necessary.	Anxiety is contagious and can be transferred from person to person. A calm attitude provides client with a feeling of safety and security. A display of strength provides reassurance for the client that the staff is in control of the situation and will provide physical security for the client, staff, and others.
Be alert to increased potential for suicidal action as mood elevates.	Client may mobilize self for suicidal attempt as decrease in depression results in increased energy and motivation.

Collaborative

Administer medication as indicated, e.g.:	
Tricyclic drugs: amitriptyline (Elavil), desipramine (Norpramin), doxepin (Sinequan), imipramine (Tofranil); selective serotonin reuptake inhibitors (SSRIs): fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil); monoamine-oxidase inhibitors: isocarboxazid (Marplan), phenelzine (Nardil);	Antidepressant medication may elevate the mood, as it increases level of energy and decreases feelings of fatigue.
Benzodiazepines: diazepam (Valium), chlordiazepoxide (Librium), alprazolam (Xanax).	Antianxiety medication may provide needed relief from anxious feelings, inducing a calming effect and inhibiting aggressive behavior.

NURSING DIAGNOSIS	**COPING, INDIVIDUAL, ineffective**
May Be Related to:	Situational/maturational crises
	Dysfunctional family system; negative role modeling; inadequate support systems
	Unmet dependency needs; low self-esteem; retarded ego development
Possibly Evidenced by:	Inability to cope/problem-solve
	Chronic worry, depressed/anxious mood
	Alteration in societal participation; manipulation of others
	Inability to meet role expectations; increased dependency; refusal to follow rules of the unit
	Numerous physical complaints
	Destructive behavior, substance abuse
Desired Outcomes/Evaluation Criteria—	Assess the current situation accurately.
Client Will:	Identify ineffective coping behaviors and consequences.
	Meet psychological needs as evidenced by appropriate expression of feelings, identification of options, and use of resources.
	Refrain from manipulating others for own gratification.

ACTIONS/INTERVENTIONS	RATIONALE
Independent	
Explain rules of the unit/therapeutic relationship and consequences of lack of cooperation. Set limits on manipulative behavior. Be consistent in enforcing the consequences when rules are broken and limits tested.	Negative reinforcement may work to decrease undesirable behaviors. Consistency among all staff members is vital if intervention is to be successful.
Ignore negative behaviors when possible and provide feedback when positive behaviors are noted, encouraging client to acknowledge own success.	Negative behaviors diminish when they provide no reward of attention. When client gives self positive feedback, inner rewards are enhanced.
Encourage client to discuss angry feelings. Help client identify the true object of the hostility. Provide physical outlets for healthy release of the hostile feelings (e.g., punching bags, pounding boards). Involve in outdoor recreation program, if available.	Verbalization of feelings with a trusted individual may help client work through unresolved issues. Physical exercise provides a safe and effective means of releasing pent-up tension, as well as of developing self-confidence and trust in others.
Take care not to reinforce dependent behaviors.	Independent accomplishment and positive reinforcement enhance self-esteem and encourage repetition of desirable behaviors.
Allow client to perform as independently as possible and provide feedback. Help client recognize aspects of life over which a measure of control is maintained/possible. (Refer to ND: Powerlessness.)	Recognition of personal control, however, minimal diminishes the feeling of powerlessness and decreases the need to manipulate others.
Give minimal attention to the physical condition if client is coping through numerous somatic complaints and organic pathology has been ruled out. Increase attention when client is not focusing on physical complaints.	Organic pathology must always be considered. Failure to do so may place the client in physical jeopardy. Lack of attention to maladaptive behaviors may decrease their repetition. Positive reinforcement encourages desirable behaviors.
Discuss the negative aspects of substance abuse as a response to stress. Help client recognize difficult life situations that may be contributing to use of substances.	Denial of problems related to substance use is common. Client needs to recognize relationship between substance use and personal problems before rehabilitation can begin.
Assist with problem-solving process. Suggest alternatives, and help client to select more adaptive strategies for coping with stress.	Because of level of anxiety and delayed development, client may require assistance in determining which methods of coping are most individually appropriate. Increased anxiety interferes with client's problem-solving ability.
Encourage client to learn relaxation techniques, use of imagery.	These skills can be helpful in developing new coping methods to deal with/reduce stress.
Collaborative	
Refer client to substance rehabilitation program if problem is identified.	A greater likelihood of success can be expected if client seeks professional assistance with this problem.

NURSING DIAGNOSIS	ADJUSTMENT, impaired [when stressor is a change in health status]
May Be Related to:	Change in health status requiring modification in lifestyle (e.g., development of chronic disease/disability, changes associated with aging process) Assault to self-esteem Inadequate support systems
Possibly Evidenced by:	Verbalization of nonacceptance of health status change Difficulty in problem-solving, decision-making, or goal-setting; lack of future-oriented thinking Lack of movement toward independence
Desired Outcomes/Evaluation Criteria—Client Will:	Recognize reality of situation and individual needs/options. Assume personal responsibility for care, problem-solve needs. Initiate necessary lifestyle changes. Plan for future needs/changes.

ACTIONS/INTERVENTIONS	RATIONALE
Independent	
Encourage client to talk about lifestyle before the change in health status.	It is important to identify the client's strengths so that they may be used to facilitate adaptation to change or loss that has occurred.
Discuss coping mechanisms that were used at stressful times in the past. Help client to discuss the change/loss and particularly to express anger associated with it.	Some individuals may not realize that anger is a normal stage in the grieving process. If it is not released appropriately, it may be turned inward on the self, leading to pathological depression.
Have client express fears associated with the change/loss or the resulting alteration in lifestyle that has occurred.	Change often creates a feeling of disequilibrium, and the individual may respond with fears that are irrational or unfounded. Client may benefit from feedback that corrects misperceptions about how life will be with the change in health status.
Assist with activities of daily living as required, but encourage independence to the limit that client's ability will allow. Give positive feedback for activities accomplished independently.	Independent accomplishments and positive feedback enhance self-esteem and encourage repetition of desired behaviors. Successes also provide hope that adaptive functioning is possible and decrease feelings of powerlessness.
Help client with decision-making regarding incorporation of change or loss into lifestyle. Identify an individual's ability to solve problems and make appropriate decisions.	The high degree of anxiety that usually accompanies a major lifestyle change often interferes with problems created by the change or loss.

Discuss alternative solutions, weighing potential benefits and consequences of each alternative. Support client's decisions.	Client may need help with this process to progress toward successful adaptation.
Role-play stressful situations that might occur in relation to the health status change.	Decreases anxiety and provides a feeling of security for the client by preparing a plan of action with which to respond appropriately when a stressful situation occurs.
Provide information regarding the physiology of the change in health status and necessity for optimal wellness. Encourage client and family to ask questions. Provide printed material explaining the change.	Helps client and family understand what has happened, clarifies information, and provides opportunity to review information at individual's leisure.

Collaborative

Refer to resources within the community (e.g., self-help/support groups, public health nurse, counselor, or social worker).	Provides assistance in adapting to the change in health status.

NURSING DIAGNOSIS	**GRIEVING, dysfunctional**
May Be Related to:	Real or perceived loss of any concept of value to the individual; bereavement overload (cumulative grief from multiple unresolved losses, excluding the death of a loved one)
	Absence of anticipatory grieving; thwarted grieving response to loss
	Feelings of guilt generated by ambivalent relationship with the lost concept/person
Possibly Evidenced by:	Idealization of the lost concept; difficulty in expressing loss; denial of loss
	Excessive anger, expressed inappropriately; labile affect
	Developmental regression
	Alterations in concentration and/or pursuit of tasks
Desired Outcomes/Evaluation Criteria—	Express emotions appropriately.
Client Will:	Demonstrate progress in dealing with stages of grief at own pace.
	Carry out activities of daily living independently.
	Express feeling of hope for the future.

ACTIONS/INTERVENTIONS	RATIONALE
Independent	
Determine stage of grief in which client is fixed. Identify behaviors associated with this stage.	Accurate baseline assessment data are necessary to choose appropriate interventions/provide effective care and evaluate progress. (Most depressed people are fixed in the anger stage, with the anger directed inward on the self.)
Convey an accepting attitude; encourage client to express self openly.	An accepting attitude enhances trust and communicates to the client that you believe the client is a worthwhile person, regardless of what may be expressed.
Encourage client to express anger. Avoid defensive response if initial expression of anger is displaced on nurse/therapist. Assist client to explore angry feelings and direct them toward the intended object/ person or other loss.	Verbalization of feelings in a nonthreatening environment may help client come to terms with unresolved issues related to the loss.
Encourage participation in large motor activities.	Physical activity provides a safe and effective method for discharging pent-up tension/anger.
Provide information about the stages of grief and the behaviors associated with each stage. Help client understand that feelings, such as anger directed toward the loss, are appropriate during the grief process.	Knowledge of the acceptability of the feelings associated with normal grieving may help relieve some of the guilt that these responses generate.
Encourage client to review relationship with loss. With support and sensitivity, point out reality of the situation in areas where misrepresentations are expressed.	Client needs to give up idealized perception and accept both positive and negative aspects about the loss before resolution of grief can occur.
Help client determine methods for more adaptive coping with the experienced loss. Provide positive feedback for strategies identified and decisions made.	Feelings of depression may interfere with client's problem-solving ability, resulting in need for assistance. Positive feedback enhances self-esteem and encourages repetition of desirable behaviors.
Collaborative	
Determine client's perception of spiritual needs as support in the grieving process. Involve chaplain or appropriate spiritual leader as indicated.	Some individuals derive great strength from spiritual support. This strength may be used by the client in the task of grief resolution.

NURSING DIAGNOSIS	HOPELESSNESS
May Be Related to:	Lifestyle of helplessness (repeated failures, dependency)
	Incomplete grief work of losses in life
	Lost belief in transcendent values/God
Possibly Evidenced by:	Verbal cues/despondent content (e.g., “I can’t,” sighing)
	Apathy/passivity, decreased response to stimuli
	Lack of initiative, nonparticipation in care or decision-making when opportunities are provided
Desired Outcomes/Evaluation Criteria—	Recognize and verbalize feelings.
Client Will:	Demonstrate independent problem-solving techniques to take control over life.
	Verbalize acceptance of life situations over which one does not have control.

ACTIONS/INTERVENTIONS	RATIONALE
Independent	
Identify use of maladaptive behaviors/defense mechanisms (e.g., withdrawal, substance use, regression).	Personal attempts to overcome feelings of hopelessness may have resulted in ineffective/harmful behaviors. Recognizing the behaviors provides opportunity for change.
Encourage client to explore and verbalize feelings and perceptions.	Identification of feelings underlying behaviors helps client to begin process of taking control of own life.
Identify individual signs of hopelessness, (e.g., decreased physical activity, social withdrawal).	Helps to individualize interventions, focus attention on areas of need.
Express hope to client in positive, low-key manner.	Even though client feels hopeless, it can be helpful to hear positive expressions from others.
Help client identify areas of life situation that are under own control.	Client’s emotional condition may interfere with ability to problem-solve. Assistance may be required to perceive the benefits and consequences of available alternatives accurately.
Encourage client to assume responsibility for own self-care (e.g., setting realistic goals, scheduling activities, making independent decisions).	Providing the client with choices increases feelings of control. **Note:** Unrealistic goals set the client up for failure and reinforce feelings of hopelessness.

Help client identify areas of life situation that are not within ability to control. Discuss feelings associated with this lack of control.	Client needs to identify and resolve feelings associated with inability to control certain life situations before level of acceptance can be achieved.

NURSING DIAGNOSIS	**SELF ESTEEM disturbance [specify]**
May Be Related to:	Maturational transitions
	Unmet dependency needs; retarded ego development
	Repeated negative feedback, diminished self-worth
	Dysfunctional family system
Possibly Evidenced by:	Self-negating verbalization, inability to deal with events; difficulty accepting positive feedback
	Lack of eye contact; nonassertive/passive behaviors; indecision, difficulty making decisions
	Hesitancy to undertake new tasks; fear of failure
	Social isolation; nonparticipation in therapy
	Manipulation of one staff member against another
	Self-destructive ideas/behavior
Desired Outcomes/Evalution Criteria—Client Will:	Identify feelings and underlying dynamics for negative perception of self.
	Demonstrate behaviors/lifestyle changes to promote positive self-esteem.
	Accept recognition for personal accomplishments/abilities.
	Verbalize increased sense of self-worth.

ACTIONS/INTERVENTIONS	RATIONALE
Independent	
Discuss goals, making sure they are realistic. Plan activities in which success is likely.	Achievement/success enhance self-concept.
Convey unconditional positive regard for the client. Promote understanding of acceptance for client as a worthwhile human being.	Unconditional acceptance of an individual serves to counteract feelings of worthlessness by reinforcing that individual is worthy of another person's respect.
Spend time with client both on a 1:1 basis and in group activities.	Conveys that the nurse sees the client as someone worth spending time with.

Assist client to identify positive aspects of self and develop plans for changing the characteristics viewed as negative.	Individuals with low self-esteem often have difficulty recognizing positive attributes. They may also lack problem-solving skills and require assistance to formulate a plan for implementing the desired changes.
Encourage and support client in confronting the fear of failure by attending therapy activities and undertaking new tasks. Offer recognition of successful endeavors and positive reinforcement for attempts made.	Recognition and positive reinforcement enhance self-esteem and encourage repetition of desirable behaviors.
Help client avoid ruminating about past failures. Withdraw attention if client persists.	Lack of attention to these undesirable behaviors may discourage their repetition. Client needs to focus on positive attributes if self-esteem is to be enhanced.
Minimize negative feedback to client. Enforce limit setting in matter-of-fact manner, imposing previously established consequences for unacceptable behavior.	Negative feedback can be extremely threatening to a person with low self-esteem, possibly aggravating the problem. Consequences need to convey unacceptability of the behavior but not the person.
Encourage independence in the performance of personal responsibilities, as well as in decision-making related to own self-care. Offer recognition and praise for accomplishments.	The ability to perform self-care activities independently enhances self-concept. Positive reinforcement encourages repetition of desirable behaviors.
Support client in critical examination of feelings, attitudes, and behaviors. Help client understand that it is acceptable for attitudes and behaviors to differ from those of others, as long as they do not become intrusive.	The need for judging the behavior of others diminishes as client increases self-esteem through greater self-awareness and the achievement of self-acceptance.

NURSING DIAGNOSIS	**SOCIAL INTERACTION, impaired**
May Be Related to:	Unmet dependency needs; retarded ego development Negative role-modeling Low self-concept
Possibly Evidenced by:	Verbalized/observed discomfort in social situations; use of unsuccessful/dysfunctional social interaction behaviors Verbalized or observed inability to receive or communicate a satisfying sense of belonging, caring, interest Exhibits behaviors unacceptable for age, as defined by dominant cultural group
Desired Outcomes/Evaluation Criteria—Client Will:	Verbalize awareness of factors resulting in difficulty in forming satisfactory relationships with others. Identify feelings that lead to poor social interactions.

Interact with staff and peers with little/no indication of discomfort.

Participate in group activities appropriately and willingly.

Identify/develop effective social support system.

ACTIONS/INTERVENTIONS	RATIONALE
Independent	
Establish 1:1 relationship with client, which serves as role model for testing new behaviors.	Client needs to learn to interact appropriately with nurse, so that behaviors may then be generalized to others.
Encourage client to engage in activities out of room/home.	Decreases opportunity for client to isolate self.
Offer to attend initial group interactions with client. Provide feedback for appropriate interactions.	Presence of a trusted individual may provide a feeling of security and decrease the anxiety generated by difficult social situation. Positive reinforcement enhances self esteem and encourages repetition of desirable behaviors.
Act as role model for client through appropriate interactions with client and others.	Because of weak ego development, client is inclined to imitate the actions of those individuals admired or trusted.
Establish schedule of group activities for client.	It is through these group interactions, with positive and negative feedback from peers, that client learns socially acceptable behavior.

NURSING DIAGNOSIS	**FAMILY PROCESSES, altered**
May Be Related to:	Situational/maturational crisis
Possibly Evidenced by:	Needs of family members not being met; confusion within family system regarding how needs should be met
	Impaired family communication; dissonance among family members
	Impairment of family decision-making process; family developmental tasks not being fulfilled
	Reduced/restricted social involvement
Desired Outcomes/Evaluation Criteria—	Express feelings freely and appropriately.
Family Will:	Develop effective patterns of communication, encouraging honest input from all members.
	Identify source(s) of dysfunction and effectively problem-solve to achieve desired resolution.

Demonstrate pattern of functioning improved from premorbid state, having gained knowledge and achieved growth from crisis situation.

ACTIONS/INTERVENTIONS	RATIONALE
Independent	
Assess family developmental stage, communication patterns, and extent of dysfunction.	Identifies specific needs and provides direction for care.
Meet with the total family group as often as possible.	The family as a system operates as a single unit. Each member affects, and is affected by, all other members. Therapy is most effective when directed toward the functioning of the family system.
Construct a client/family genogram.	Genograms help identify emotional closeness among family members over several generations. Family process is clarified, and configuration and dynamics are clearly illustrated.
Assist family to identify true source of conflict. Help them recognize that "identified patient's" adjustment disorder may be a way to avoid confronting the real problem.	Conflict creates high levels of anxiety within the family system. Common defense mechanisms such as denial, displacement, projection, and rationalization are used by the family to decrease anxiety and avoid conflict.
Encourage family members to set goals and identify alternatives. Support efforts directed toward positive change. Assist with necessary modifications of original plan.	Life crises interfere with family decision-making and problem-solving abilities. Assistance with this process may be required to promote adaptation and growth.
Promote separation and individuation and clear, functional boundaries between/among members. function autonomously.	Emotional connectedness among family members (enmeshment) discourages individual growth and ability to
Help client-family identify actions/problem-solve for potential life crises.	Anticipatory guidance/knowing what to expect and having a plan of action for management of situations may help to avert a crisis in the future.
Collaborative	
Involve family in group therapy.	Interacting with others in family/multifamily groups can help identify dysfunctional patterns and assist in learning new skills and solutions for family problems.
Refer family to other resources, such as support groups, classes (e.g., parenting/assertiveness training).	Sharing with others who have had similar experiences can provide support and assist family members to learn new ways to deal with situation.