

CONDUCT DISORDER

DSM-IV

312.XX Conduct disorder

312.81 Childhood-onset type

312.82 Adolescent-onset type

Conduct disorder is most distinguishable by the degree of repetitive and persistent violation of the basic rights of others. Common antisocial behaviors acted out in the home and school setting include physical aggression toward people and animals, destruction of property, lying, and theft. There is a total disregard for age-appropriate social norms as the child purposely engages in criminal acts, truancy from school, and breaking curfew. The *DSM-IV* criteria rates the level of severity as *mild, moderate, to severe*. The greater the level of delinquency and frequency in early childhood, the greater the risk for chronic offending into adulthood. Other prognostic factors leading to the continuation of the disorder include age of onset and the variation in problem behaviors displayed in multiple settings. Co-morbid diagnoses often associated with this condition are hyperactivity, depression, and chemical abuse and dependence.

ETIOLOGICAL THEORIES

Psychodynamics

According to psychoanalytical theory, these children are fixated in the separation-individuation phase of development. The mother figure projects her view of the child's needs as an unrealistic demand on her. The child cannot solidify attachment with the maternal object and compensates for the mother's narcissistic need for gratification by *overridealizing* the image of the mother. The child fails to build up identification and differentiation between self and others to support sufficient superego development. The id behavior is prominent.

Biological

Temperamental abnormalities have been observed in infants at birth in terms of excitability, attention span, and adaptability. Heredity influences such traits as the tendency to seek risks and obey authority. One possibility is the biological influence of heightened arousal in the CNS and abnormally high levels of testosterone, leading to aggression. Differences in the lack of sufficient serotonin transmission is evidenced.

Current research suggests that negative experiences in infancy cause biological and neurological damage to the brain tissue. When persistent stress results in an internal perception of a constant state of danger, the "*fight-or-flight*" hormones (adrenaline and cortisol) are released, reaching dangerously high levels that can cause neurological impairment. These damaged brain cells react in unusual ways to the stimuli, possibly resulting in epileptic seizures or depression.

Family Dynamics

Certain family patterns contribute to the disruptive behavior. A high correlation exists between chronic conflict and neglect in the parent-child relationship. Poor parental management skills, inconsistent or rigid and harsh discipline practices increase the risk for acting out by the child. Changes in caretakers, unstable spousal relationships, and parental rejection are all contributing/causal factors. These children lack strong emotional bonds or reliable role models to promote prosocial behavior. Socioeconomic conditions may also play a part, with poverty being a risk factor.

CLIENT ASSESSMENT DATA BASE

Ego Integrity

Feelings of rejection, powerlessness

Blames others for what happens to self
Displays maladaptive coping behaviors; uses manipulation to get needs met
Engages in unacceptable behaviors in response to stressors (e.g., staying out at night, running away)
May have had frequent/recurrent life changes, (e.g., multiple moves, change of schools, lifestyle changes, placement in foster homes)

Food/Fluid

Skips meals, eats excessive amounts of junk foods
Eats in response to external cues/stressors
Reports of nausea
May have excessive weight for height; recent weight gain may be noted

Hygiene

Poor hygiene/personal habits
Style of dress may reflect fashion trends or be atypical (antisocial/gang attire)

Neurosensory

Nervousness, worry, and jitteriness/excessive psychomotor activity
May be depressed, angry, or react with ambivalence or hostility; poor impulse control
Affect may be labile
Physical characteristics/development may not be normal for age range

Safety

Engages in risk-taking behavior (e.g., gang involvement, exposure to STDs, drug use)
Overt aggressive acts
Suicidal ideation; may have plan/means, previous suicide attempts

Sexuality

Early onset of sexual behavior, may have forced others into sexual activity

Social Interactions

Symptoms most often appear during prepubertal to pubertal period and may predispose the child to conduct or adjustment disorders in adolescence
Family disharmony/disruption, little contact with absent parent/separation from extended family may be reported
Individual may have history of poor school/work performance
Parents may report client isolates self, plays stereo loudly, does not participate in family activities; shows little empathy or concern for others
Displays hostility toward authority figures; intimidates others
Participation in social activities may be nonexistent or sporadic, or gang-related
Client may be involved with legal system/juvenile court, have record of antisocial behavior (e.g., fire-setting, cruelty to people/animals, stealing, use of a weapon)

Teaching/Learning

Onset usually between age 5 to early adolescence; rare after age 16
May be involved in drug use/abuse (e.g., alcohol, inhalants, cigarettes/chewing tobacco)
May have had previous psychiatric hospitalization for same or other problems

DIAGNOSTIC STUDIES

Drug Screen: To identify substance use/abuse.

NURSING PRIORITIES

1. Provide a safe environment and protect client from self-harm.
2. Promote development of strategies that regulate impulse control, regain sense of self-worth and security.
3. Facilitate learning of appropriate and satisfying methods of dealing with stressors/feelings.
4. Promote client's ability to engage in satisfying relationships with family members and peer group.
5. Increase the client's behavioral response repertoire.

DISCHARGE GOALS

1. Exhibits effective coping skills in dealing with problems.
2. Understands need and strategies for controlling negative impulses/acting-out behaviors.
3. Expresses anger in appropriate/nonviolent ways.
4. Family involved in group therapy; participating in treatment program.
5. Plan in place to meet needs after discharge.

NURSING DIAGNOSIS

Risk Factors May Include:

[Possible Indicators:]

Desired Outcomes/Evaluation Criteria—

Client Will:

VIOLENCE, risk for, directed at self/others

Retarded ego development; loss of self-esteem; antisocial character

Dysfunctional family system and loss of significant relationships; feelings of rejection, sense of powerlessness

Poor impulse control

History of suicidal/acting-out behavior

Behavior changes (e.g., absenteeism, poor grades, hostility toward authority figures, stealing)

Increased motor activity, increasing anxiety level, anger

Overt aggressive acts directed at the environment

Self-destructive behavior, active suicidal threat/gestures

Verbalize understanding of behavior and factors

that precipitate violent actions.

Express anger in appropriate ways, avoiding hostile or suicidal gestures/statements or harm to self or others.

Demonstrate self-initiated intervention strategies that facilitate more effective coping skills.

Identify and use resources and support systems in an effective manner.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Establish trusting relationship with client. Encourage exploration and verbalization of feelings.

Client's expression of internal conflicts, in words rather than action, will more likely be made to knowledgeable and accepting staff.

Strike a balance in the intimacy of the therapeutic relationship.

Children who are more disturbed respond best to a less-intrusive relationship in the beginning.

Monitor stressors and warning signals such as behavior changes, anger, anxiety, and recently disrupted family.

Impulsive reactions to stressful situations, directed toward harm to self or others, may be a cry for help.

Observe/assist client to recognize mood (e.g., anger, sadness, anxiety).

Identifying own feelings is the first step in the change process. Signs and symptoms of anxiety need to be identified before client can begin to make constructive changes.

Identify antecedents to violent behavior.

Correct assessment and interpretation of premonitory conditions provide for timely intervention to reduce risk of violent/acting-out behavior.

Support client's exploration to identify behaviors or interventions that offer relief.

Connecting feelings with behaviors that afford relief will encourage the development of more productive behaviors.

Determine seriousness of suicidal tendency, gestures, threats, or previous attempts. (Use scale of 1–10 and prioritize according to severity of threat, availability of means.)

Knowledge of past and present behavior in reference to suicidal ideation will assist in assessing client's tolerance for stress, degree of concern. **Note:** This may be first-priority nursing diagnosis if suicide risk is rated in the 8–10 range.

Provide information regarding suicidal ideation/warnings. Include significant other(s) in discussions.

Client may be unaware or/ignorant of meaning of warning signals when suicidal ideation exists.

Maintain a therapeutic milieu that includes a safe environment (e.g., suicide precautions, behavioral contract).

Internal controls may be inadequate, requiring some external controls and interventions until internal control is learned.

Observe client unobtrusively for signs of potential violence toward others.

Intervention before the onset of violence can prevent injury to the client and others. Overt monitoring may be interpreted negatively and potentiate acting-out behavior.

Explore and offer more satisfying alternatives to aggressive behavior (e.g., physical outlets for redirection of angry feelings; use of quiet room, or "Soft Spot" with soft balls/pillows to pound).

Increased ability to discover satisfying alternatives in coping with stressors will decrease need for aggressive behavior. Physical outlets help relieve pent-up tension and anxiety.

Engage in action-oriented recreational therapy (e.g., exercise activities [jogging in the gym, etc.], outdoor program, wall climbing, noncompetitive games/supervised sports).

Recreational therapy helps discharge nervous, pent-up energy, releasing tension and reducing anxiety. Sustained activity stimulates release of endorphins, enhancing sense of well-being. Formal

Establish hierarchy of responses to aggressive behaviors (e.g., Time out). Have sufficient staff available to indicate a show of strength to client if it becomes necessary.

Encourage client to ask for time with staff, give permission to express angry feelings. Be alert to “acting out” to please peers or nursing staff.

Assess how unit functioning affects adolescent behaviors.

Have staff member stay with client when necessary. Encourage client to choose own “Time out,” going to room for alone time, taking medications; or choosing room schedules, use of seclusion and/or restraints.

Include whole community/classroom in reinforcing positive behaviors. Use daily goal-setting group or problem-solving group.

Collaborative

Place in seclusion or apply restraints as necessary.

Administer/supervise medications and monitor effects of therapy.

exercise therapy programs are an adjunct to psychotherapy, decreasing symptoms related to anxiety, depression, and thought disturbances. Exercise does not need to be aerobic or intensive to achieve desired effect. **Note:** Competitive games may increase anxiety.

This conveys to client evidence of control over the situation and provides some sense of security for the client and staff.

Early interventions can interrupt the pattern prior to seriously escalating behavior. Recognizing feelings and taking responsibility by asking for time to discuss them helps the adolescent learn more effective ways of dealing with problems that can lead to anger and acting-out behaviors.

Milieu stressors like vacations, personnel changes, and staff conflict can affect client’s own issues (e.g., abandonment). It is important to look at the psychodynamics as well as the unique meaning of individual behavior.

Staff member can help client to express feelings and begin to recognize value of appropriate handling of anger. Adolescent may see “Time out” as punishment if staff imposes, but begins to take responsibility for self by recognizing and choosing own quiet/alone time.

Peer interaction is effective in this age group to help client control own behavior.

External restraints may be needed until client regains control of own behavior.

Helps client to maintain impulse control. Neuroleptic medications decrease aggressive outbursts and improve impulse control.

NURSING DIAGNOSIS

May Be Related to:

Possibly Evidenced by:

THOUGHT PROCESSES, altered

Physiological changes—damage to brain tissues

Lack of psychological conflicts

Biochemical changes—substance use/abuse

Inaccurate interpretation of stimuli; tendency to interpret the intentions and actions of others as blaming and hostile

**Desired Outcomes/Evaluation Criteria—
Client Will:**

Deficits in problem-solving skills, perceptions, and self-statements; demonstrating fewer solutions to interpersonal problems—physical aggression is the solution most often chosen

Describe how thoughts and emotions relate to own behavior.

List characteristics of the antisocial personality that client sees in self.

Explain the concept of thinking error, how it leads to antisocial behavior, and name those that personally apply.

Practice new cognitive problem-solving skills that will lead to social competence and adjustment.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assign primary nurse to develop a therapeutic relationship.

Continuity of care for client builds trust and clarifies expectation.

Discuss characteristics of the antisocial personality with the client.

Some common beliefs of the person with an antisocial personality are as follows: does not have to conform to society's rules or norms, believes the world revolves around self, and believes that others should meet client's needs rather than client meeting society's expectations.

Provide written handout and allow time for client to review information, ask questions, and clarify understanding

Allows client to internalize information and prepares for restructuring activities to change behavior.

Discuss the concept of thinking errors.

A thinking error occurs when a person has a thought that is extremely different from the way most people under the same circumstances would think. If the person acts on the thought, the behavior will be outside of societal norms.

Relate concept to client's own thinking errors and behavior.

Common thinking errors are as follows: victim stance ("He started it/I couldn't help stop to think how actions will hurt others; lack of effort; unwillingness to do anything perceived as boring or disagreeable; refusal to accept obligation, ("I forgot/I don't have to"); gaining power through anger; refusal to acknowledge fear; blaming others when criticized; "I can't" attitude—statement of refusal, not inability.

Have client keep a "thinking log," emphasizing the importance of writing actual thoughts and not trying to "con" the staff with what the client thinks they

Provides opportunity for client to "see" thoughts and compare with reality, connect outcomes/consequences with specific behaviors, and begin to

want to hear. Explain responsibility for daily entry and attendant consequence.

Promote client responsibility for the review process. Help client identify the thinking errors and relate them to the client's pattern of thinking in everyday life. Reinforce that the thinking errors are only the "tip of the iceberg."

Observe for shame reactions. Explain that the process is not judgmental and discuss behavioral responses.

Require attendance at Thinking Error Group. Facilitate honest noncritical feedback from group members. Continuously evaluate the group process and identify thinking errors as they occur in the group.

Review entire log with client before discharge. Provide feedback regarding improved behavioral responses and areas in which continued work is needed. Encourage client to continue thinking log after discharge.

take responsibility for change process.

Helps client begin to assume inner-directed self-control. Promotes attention to content and conformity to process, allowing client to begin to identify ineffective methods of getting needs met.

Thinking log is a tool for client to identify thinking errors and choose not to act on them.

Sharing information from the log promotes awareness and opportunities to change behavior in safe environment of the group.

This provides opportunity for client to identify predominant pattern of thinking errors and recognize new ways to respond that have been learned in treatment.

NURSING DIAGNOSIS**May Be Related to:****Possibly Evidenced by:****Desired Outcomes/Evaluation Criteria—****Client Will:**

SOCIAL INTERACTION, impaired

Lack of social skills

Developmental state (adolescence)

Verbalized or observed discomfort in social situations and use of unsuccessful social interaction behaviors

Dysfunctional interactions with peers, family, and/or others

Family report of change of style or pattern of interaction

Self-concept disturbance

Verbalize awareness of factors and identify

feelings related to impaired social interactions.

Be involved in achieving positive changes in social behaviors and interpersonal relationships.

Develop effective social support systems.

ACTIONS/INTERVENTIONS**Independent**

Assess individual causes and contributing factors (e.g., disruption of the family, frequent moves during

RATIONALE

Although learning social skills is one of the maturational tasks, many factors can interfere with

child's/adolescent's life, individual's poor coping and adjustment to developmental stage).

Review medical history.

Observe family patterns of relating and social behaviors. Explore possible family scripting of expectations of the child/adolescent. Note prevalent patterns.

Encourage client to verbalize feelings about discomfort in social settings, noting recurring factors or precipitating patterns.

Active-listen verbalizations indicating hopelessness, powerlessness, fear, anxiety, grief, anger, feeling unloved or unlovable, problems with sexual identity, and/or hate (directed or not).

Assess client's coping skills and defense mechanisms.

Have client identify behaviors that cause discomfort and review negative behaviors others have identified.

Explore with client and role-play new ways of handling identified behaviors/situations.

Provide reinforcement for positive social behaviors and interactions.

Work with client to correct basic negative self-concept (Refer to ND: Self Esteem, chronic low).

Help client identify responsibility for own behavior. Encourage keeping a daily journal of social interactions and feelings.

Collaborative

Involve in group therapy as indicated.

Encourage reading, attendance at classes (e.g., positive image, self-help, assertiveness), and community support groups.

the client's ability to interact satisfactorily with others in social situations.

Long-term illness/accident may have interfered with development of social skills at earlier stages.

Family may not have effective patterns of relating to others, and the child learns these skills in this setting. Often child reflects family expectations rather than own desires. Identification of patterns will help with plan for change.

Client identifies areas of concern and suggests ways to learn new skills.

Client may believe that nothing can be done to change the way things are and that own actions do not make a difference. Active-listening client's words and feelings conveys a message of confidence in the individual's own abilities.

Although skills may have helped client to "survive" in the past, their use was often based on thinking errors/misinterpretation of the situation. These skills may be effective for dealing with restructured reality and/or provide a base for learning new skills.

Listing specific behaviors will help the client know where change is possible. Knowing what others see can help the client accept and effect change.

Active involvement is the most effective way to create change.

Promotes feelings of self-worth and helps reinforce desired behaviors.

Negative self-concepts may be a major factor impeding positive social interactions.

Enhances self-esteem and provides feedback to improve skills. Journaling can provide an ongoing record to note improvement and/or areas of need for change.

Helpful arena to practice new social skills and to receive feedback with support for efforts to improve.

Assists in alleviating negative self-concepts that lead to impaired social interactions.

NURSING DIAGNOSIS**May Be Related to:****Possibly Evidenced by:****Desired Outcomes/Evaluation Criteria—
Client Will:****Desired Outcomes/Evaluation Criteria—
Client Will (cont.):****COPING, defensive**

Inadequate coping strategies; maturational crisis; multiple life changes/losses

Lack of control of impulsive actions; personal vulnerability

Denial of obvious problems/weaknesses; projection of blame/responsibility; rationalizing failures

Difficulty in reality-testing perceptions; grandiosity

Inappropriate use of defense mechanisms (e.g., stealing and other acting-out behaviors, excessive smoking/drinking)

Inability to meet role expectations

Difficulty establishing/maintaining relationships; hostile laughter at, or ridicule of, others; superior attitude toward others; hypersensitivity to slight or criticism

Verbalize and recognize significance of losses in life.

Verbalize understanding of the relationship between emotional needs and acting-out impulsive behaviors and the consequences thereof.

Develop ego strength sufficient to cope with inner impulses.

Identify and demonstrate ways to meet own needs.

Participate in treatment program/therapy.

ACTIONS/INTERVENTIONS

RATIONALE**Independent**

Establish level of authority of primary nurse; monitor the need for nurturance and limit-setting.

Provide explanation of the rules of the treatment setting and develop consequences with the client for his or her lack of cooperation.

Encourage client to express fears and concerns.

Listen to client's perception of inability to adapt to situations occurring at present.

Help client to recognize significance of losses and express feelings regarding these.

Consistent "parent figure" can uniformly reinforce consequences of behaviors of the client.

Clear explanation of the rules allows the client to make choices about participating. Involvement in setting of the consequences promotes an investment in which the client is more apt to comply.

Self-understanding and further exploration are enhanced when verbalizations of concern and anxiety are received in a nonjudgmental manner.

Provides clues to reality of these perceptions and avenues to assist in dealing with them.

Grief work cannot begin until losses are acknowledged (e.g., divorce, relocation, loss of friends/extended family/support systems).

Encourage exploration of the relationship of behavior, anxiety, and somatic symptoms to the grief process.

Discuss appropriateness and desirability of the grief process as it relates to the loss(es). Discuss stages of the grief process and behaviors associated with each stage.

Determine coping mechanisms used (e.g., projection, rationalization) and how these affect current situation.

Assist client to recognize the reality and nonproductivity of maladaptive behaviors (e.g., failing grades, trouble with the law, running away). Offer support and confront client when appropriate.

Describe all aspects of the problems using therapeutic communication skills (e.g., Active-listening).

Focus on specific behaviors (e.g., poor academic performance, antisocial behavior) that are amenable to change.

Set limits on manipulative behavior by telling client what will be tolerated; be consistent in enforcing consequences when rules are broken and limits tested.

Reinforce client positively when change in behaviors indicates effective coping through behavior-modification system. Anticipate and accept occasional regressive behavior.

Identify past and present support systems.

Explore religious beliefs/affiliations. Encourage client to draw again on spiritual resources that had been useful in the past.

Explore possible ways to rekindle relationships with positive peer/role models, influential adults, organizations/church youth group, as appropriate.

Encourage the development of a positive relationship with an adult.

Knowledge regarding possible psychological and physiological manifestations of the grief process helps identify etiology of existing symptoms and to alleviate denial.

Grief work is necessary and a natural reaction to loss. Time is required (at least 6–12 months) to work through grief. The process gives the client permission to grieve and offers hope for eventual acclimation to the loss.

Provides a beginning point for client to see how use of ineffective coping methods causes problems in life/relationships.

Old patterns of behavior tend to recur under stress. Continuous monitoring of behavior is necessary to avoid old, nonproductive methods of coping and problem-solving. Therapeutic confrontation can help client to look at incongruencies of behavior and own responsibility for actions.

This clarifies problems and promotes understanding by the client and nurse.

Energy is best used when focus is on those areas that can be altered.

Being clear and confronting these behaviors in a consistent manner will help client begin to change ways of getting needs met.

Adolescence is a time of stress and vulnerability because of a lack of well-developed coping skills. Positive reinforcement encourages continuing personal growth. Hospitalization may precipitate periodic regression.

Reinforces availability of resources to aid the client to develop new coping skills.

When these ties have been previously established, they may be helpful in providing resources for the adolescent to enhance inner controls.

Attaining peer acceptance is of primary importance during adolescence. Peer groups that share common values promote the formation of belonging and identity.

A quality relationship with an adult (preferably a parent) reinforces the strength and supportive function of the relationship (family) and is a positive factor when setting limits with the adolescent.

NURSING DIAGNOSIS**FAMILY COPING, ineffective: compromised/disabling****May Be Related to:**

Loss of significant relationship (parent/child); lack of effective parent management skills

Highly ambivalent family relationships; family disorganization/role changes

Presence of other situational/developmental crises affecting family members

Possibly Evidenced by:

Client states feelings of abandonment, rejection, and guilt about parent's response to adolescent's problems

Client expresses sense of powerlessness and lack of control

Parents describe preoccupation with own reactions (e.g., fear, guilt, anxiety)

Parents withdraw or have limited communication with adolescent or display protective behavior disproportionate (too little or too much) to client's abilities or need for autonomy

Desired Outcomes/Evaluation Criteria—

Express feelings openly and honestly.

Family Will:

Evaluate individual role in family problems.

Initiate positive/amicable relationship with one another.

Desired Outcomes/Evaluation Criteria—

Promote prosocial behaviors by role-modeling

Family Will (cont.):

appropriate behaviors in the home.

Identify need for/seek outside support as appropriate.

ACTIONS/INTERVENTIONS**RATIONALE**

Independent

Foster trust through 1:1 family/nurse relationship.

Basic trust and stability can be established through continuity and consistency of care.

Identify underlying family dynamics and determine how they are operating in the present.

Established family patterns affect how current situation has arisen, as well as how problems need to be resolved and changed now.

Encourage open communication between client and family.

Communication patterns affect the functional level of each family member.

Encourage client to identify and appropriately verbalize feelings of rejection, abandonment, and ambivalence related to individual situation.

Verbalizing feelings tends to alleviate tensions that may be internalized or somatized (e.g., reports of nausea). Client lacks emotional attachment to others and may be charming and engaging, which is a pretense to deceive others/facilitate exploitation.

Discuss reasons for client behaviors, including the relationship between differences in the client's thoughts/beliefs and how others in the family think

Understanding of childhood/adolescent tasks, ambivalent feelings, etc., can help individual(s) accept and deal more appropriately with difficult

and behave.

Explore feelings of self-blame and guilt related to problems/changes in the family system. Assist individuals in realistic appraisal and verbalization of own role in situation.

Guide client/family in correlating anger and feelings that are centered around lack of influence in family behavior.

Encourage client/family to make as many decisions as are possible within the milieu. **Example:** Client decision to participate in choice of evening activity.

Focus on specific behaviors that are amenable to change.

Help family recognize and set limits on manipulative behavior.

Explore ways client and family can be mutually supportive without fostering overdependence on each other.

Give immediate, consistent, and positive reinforcement when desired behaviors are observed. Conversely, withhold reinforcement/ignore negative behaviors.

Collaborative

Explore potential sources of assistance available to meet needs. Refer to social services and other agencies as indicated.

Encourage family to participate in family therapy.

behaviors. As a rule, client is easily bored and has a low frustration tolerance when desires are not immediately gratified. Emotional reactions can be erratic and demonstrate a lack of concern for others. When the client acts on his or her thoughts, behavior will be outside of societal norms.

Change or disruption in the family system affects all other parts of the system. Children may incorrectly assume that they were instrumental in family problems/marital disruption.

Understanding internal dynamics of anger leads to acceptance of locus of control within self.

An increase in autonomy and decision-making enhances feeling of self-worth and competency.

Changing some behaviors can enhance feelings of self-esteem and encourage willingness to make other changes.

Stating rules clearly and being consistent in maintaining them helps establish family boundaries and allows the client to recognize when they are violated.

Security and trust provide a climate for growth and risk-taking.

Consistent reinforcement of appropriate behaviors fosters continuation of those behaviors. Consequences for inappropriate behaviors and no reinforcement (ignoring) tend to extinguish undesired behaviors.

Knowledge of resources available if they are needed tends to decrease fears regarding postdischarge functioning.

Enables family to work on issues that affect all of the family system. **Note:** Family rift may be so severe that the most that can be expected is a neutral relationship in which parties agree to disagree. (Refer to CP: Parenting.)

NURSING DIAGNOSIS

May Be Related to:

SELF ESTEEM, chronic low

Life choices perpetuating failure (e.g., runaway behavior)

Possibly Evidenced by:

Personal vulnerability (loss of family member/ friends; poor school performance, relocation)

Fixation in earlier level of development (lack of movement toward independence)

Self-negating verbalizations, self-blame, anger

Rationalizing away/rejecting of positive feedback and exaggeration of negative feedback about self, feelings of rejection

Frequent lack of success in school/other life events

**Desired Outcomes/Evaluation Criteria—
Client Will:**

Verbalize beginning understanding of negative evaluation of self and reasons for problems.

Participate in treatment program to promote change in self-evaluation.

Demonstrate behaviors/lifestyle changes to promote positive self-esteem.

Verbalize increased sense of self-esteem in relation to current situation.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Continue the trust relationship that is reliable, supportive, and reassuring.

Communication, growth, and insight flourish in an atmosphere of acceptance and trust.

Schedule time for 1:1 client/nurse interaction and communication.

Individual attention conveys the importance of the individual. Communication skills are refined with frequent interaction.

Explore and discuss feelings of rejection and anger related to individual situation.

Recognition and expression of feelings eliminate need for displacement and denial. This directs focus of energy to problems and alternative solutions.

Point out past academic/personal successes.

Assists in preserving self-esteem. Past performance is a more accurate portrayal of ability than that indicated by recent evaluations/grades.

Assist client in understanding transient nature of poor academic performance related to current stressors.

High-anxiety levels affect motivation, attention to task, and performance.

Work with client to develop a plan of action to meet immediate needs (e.g., physical safety, hygiene, emotional support).

Provides opportunity for client to learn sense of control and fosters self-esteem.

Maintain positive attitude toward the client, providing opportunities for client to exercise control as much as possible.

Cooperation can be enhanced when client feels accepted and included in problem-solving and decision-making.

Encourage activities in areas of client's interest, tasks that can be completed successfully, and reinforce when these are accomplished.

Provide opportunities for client to make short-term attainable goals (e.g., crafts, activities).

Encourage participation in activities with peer group (e.g., outings, hikes, swimming).

Involve in activities to improve personal appearance (e.g., makeup, hairstyling, clothing choices).

Use the technique of role rehearsal to help the client develop new skills to cope with changes.

Collaborative

Consult with resident educational therapist (teacher) regarding academic pursuits while client is hospitalized (residential treatment program).

Schedule staffings with "home" school counselors, social worker, teachers, and client/parents as possible.

Success in accomplishing goals builds sense of self and diminishes need for disruptive acting-out behaviors.

Promotes feelings of self-worth, which can lead to increased appropriate risk-taking and the development of more elaborate future-oriented goals.

Social interaction and peer acceptance are among the tasks of this developmental stage. Participation helps to develop social skills.

How an individual looks affects feelings about inner self and can improve sense of self.

Active participation in activity enhances learning.

Keeping up with class work can help to lessen further loss of self-esteem. Can be an opportunity to form a positive relationship with teacher and experience learning successes fostering personal growth and improved self-worth.

This maintains contact with own public/private school setting; fosters continuity for return and sense of importance for the student.

NURSING DIAGNOSIS

May Be Related to:

Possibly Evidenced by:

Desired Outcomes/Evaluation Criteria— Client Will:

NUTRITION, altered: less than/more than body requirements

Inadequate intake of balanced, nutritional meals because of lifestyle

Reported/observed inadequate food intake and lack of weight gain, or excessive intake in relation to metabolic need with subsequent weight gain

Satisfaction of hunger through consumption of excessive amounts of junk food

Verbalize understanding of the relationship of food intake, exercise, and metabolism.

Demonstrate positive eating habits with appropriate nutritional intake.

Achieve desired weight level.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Encourage client to eat well-balanced meals on a regular basis.

Provide information regarding nutritional intake and selection of appropriate foods that will encourage weight loss/gain as indicated.

Assist client in developing insight into eating habits as they relate to feelings of anxiety. Encourage keeping a diary of food intake and related feeling(s).

Review daily intake diary, activity level.

Identify blocks to adequate nutritional intake.

Hunger can be satisfied with nutritious food intake, eliminating empty calories.

The correlation of food intake and weight gain/loss, if understood, can lead to food choices that result in achieving appropriate weight. Foods that are self-selected are more likely to be eaten and enjoyed.

Increased anxiety may lead to anorexia or frequent snacking as a response to feelings of tension.

This identifies reality of adequate intake in relation to energy output and helps child/family to make decision for change.

Factors such as substance abuse, smoking, limited/inappropriate use of financial resources, and poor family patterns may interfere with child developing healthy eating habits.

Collaborative

Refer to dietitian as needed.

Helps determine individual caloric needs while considering child/adolescent dietary preferences.