

DISSOCIATIVE DISORDERS

DSM-IV

- 300.12 Dissociative amnesia
- 300.13 Dissociative fugue
- 300.14 Dissociative identity disorder
- 300.15 Dissociative disorder NOS
- 300.6 Depersonalization disorder

In these disorders a disturbance or alteration exists in the normally integrative functions of identity, memory, or consciousness. The individual blocks off part of his or her life from consciousness during periods of intolerable stress. The stressful emotion becomes a separate entity, as the individual “splits” from it and mentally drifts into a fantasy state.

ETIOLOGICAL THEORIES

Psychodynamics

Selective repression of distressing mental contents from conscious awareness is used as a mechanism for protecting the individual from emotional pain or expressing self in dangerous ways. The stressor(s) may arise from external circumstances or internal sources with onset of symptoms sudden or gradual and of transient or chronic nature. Intrapsychic conflict thus uses denial and “ego splitting” to decrease anxiety.

Physical sensations seen in these disorders may represent forbidden wishes that have been somatized. The use of the defense mechanism of displacement allows the feeling(s) to be directed away from the ego-threatening object toward one less threatening. In psychoanalytic terms, dissociation is a form of denial in which the object denied is part of the self or ego.

Biological

Research on the biological basis of these disorders is increasing as more recognition of the mind-body connection is accepted. It is difficult to determine whether the biological changes (fight-or-flight mechanism) that accompany severe anxiety precede or precipitate the emotional state. Biochemical, physiological, and endocrine systems have an intimate connection with actual physical changes occurring in all body systems via the autonomic nervous system. Some studies have shown EEG abnormalities associated with cerebral mechanisms in the temporal and limbic regions of the brain, which mediate identity formation and a sense of personal boundaries and may affect development of gender and generation boundaries.

Organic causes of pathological dissociative experiences that are known or suspected include temporal lobe epilepsy, sensory deprivation, sleep loss, strokes, encephalitis, and Alzheimer’s disease. Drugs may also induce amnesia or depersonalization directly or indirectly in some incidences. However, most dissociative states are not associated with any obvious organic conditions and the diagnosis of dissociative disorder requires that the condition is not due to the direct effects of a substance or a general medical condition.

Family Dynamics

In Systems theory, the family is viewed as a system in which the process (interactions between/among family members) is the prime determinant. Level of differentiation and level of anxiety determine the degree of pathology.

Psychosocial theory states that individuals who develop dissociative disorders have often experienced severe physical, sexual, and/or emotional abuse early in life—stress so severe that the only way to cope with the painful emotions is to detach from them. The child learns to respond to stressful situations in this manner. One parent may be abusive, with the other being a passive participant, not taking care of or protecting the child. Psychiatric diagnoses (especially alcoholism) in close relatives are common, although multiple personality diagnosis is not.

Certain behaviors observed in childhood, though considered normal, may be identified as dissociative, including construction of imaginary playmates, use of different names or ages for themselves, taking on the role of an animal, imagining self as having been adopted or coming from another family, separation from the past, gender confusion, and regressive behavior. Responding to stressful situations with dissociative behaviors then becomes a method of coping for some individuals into adulthood, when there is less control over the dissociative states. The response becomes maladaptive in that the individual escapes from the stressful situation rather than facing it.

CLIENT ASSESSMENT DATA BASE

Activity/Rest

Insomnia

Ego Integrity

Confusion about personal identity, may have assumed a new identity either partial or complete (fugue)
Anxiety responses, report of phobias; fears of going crazy

Neurosensory

Memory lapses/amnesia; disorientation; inability to recall important personal information/specific incidents not due to direct effects of a substance, general medical condition, or ordinary forgetfulness

May report hallucinations, delusions

Mood swings; psychological conflicts; family/peers may describe client's behavior as erratic, unpredictable, or unreliable

Sudden, unexpected travel away from familiar surroundings of work and home, with inability to recall past (fugue)

Persistent/recurrent experiences of feeling detached from own mental processes or body, although reality testing remains intact (depersonalization)

Presence of 2 or more distinct identities or personality states (mean average of 13), with each a fully integrated, complex unit with unique memories, behaviors, and relationships (or may be a personality state that does not have as wide a range of patterns) recurrently taking control of client's behavior, with transition from one personality to another being sudden/associated with psychosocial stress. Alternate personalities vary in their awareness of each other, may be of opposite genders, and are commonly children, although some may be stated to be older than the individual (dissociative identity disorder)

Transient changes in facial expression, voice, and posture; tastes/habits that seem to change quickly or often

Safety

Suicidal feelings/behaviors
Evidence of self-mutilation

Sexuality

History of severe childhood incest, sexual/physical/psychological abuse
Sexually inhibited or promiscuous

Social Interactions

Significant distress or impairment in social, occupation, or other important areas of functioning

Teaching/Learning

More common in women than in men, in persons with some higher education, and in white-collar workers
Age of onset is early childhood, although often not diagnosed until the third decade
Seldom diagnosed upon initial clinical contact (accurate diagnosis may be delayed by a period of months to years)
Substance abuse may be reported (but is not cause of disorder)
Absence of organic brain disorders (e.g., temporal lobe epilepsy)
History of major depression greater than 90% (dissociative identity disorder)

DIAGNOSTIC STUDIES

(Evaluations to rule out an underlying or concurrent disease process are based on individual symptoms.)

Neurological Testing (e.g., EEG and CT/MRI Scans): To rule out organic brain conditions related to trauma, tumor, congenital defects, and temporal lobe epilepsy, symptoms of which often parallel manifestations of dissociative identity disorder.

Psychosocial Assessment, such as Rorschach, Thematic Apperception Test (TAT), Minnesota Multiphasic Personality Inventory (MMPI), Weschler Adult Intelligence Scale (WAIS), Dissociative Experiences Scale (DES), Dissociative Disorders Interview Schedule (DDIS), and Hypnosis or Amobarbital Interviews: As indicated to provide behavioral observation and documentation describing the character, duration, frequency, and precipitation of behavioral changes and client comments or complaints essential to the diagnostic process, as these clients are frequently misdiagnosed initially because of blurring of symptoms that parallel other psychiatric problems—commonly depression, neuroses, personality disorders, and schizophrenia.

Drug Screen: Assess for concomitant substance use.

NURSING PRIORITIES

1. Provide safe environment; protect client/others from injury.
2. Assist client to recognize anxiety.
3. Promote insight into relationship between anxiety and development of dissociative state/other personalities.
4. Support client/family in developing effective coping skills and participating in therapeutic activities.

DISCHARGE GOALS

1. Recognizes potentially dangerous behaviors/personalities and contracts for safety.
2. Client/family are participating in therapeutic regimen.
3. Effective coping skills, understanding of underlying dynamics of condition are demonstrated.
4. Recovers deficits in memory.
5. Major/emerging personality has been chosen and accepted (dissociative identity disorder) or client is managing stress without resorting to dissociation.
6. Plan in place to meet needs after discharge.

NURSING DIAGNOSIS

ANXIETY [severe/panic]/FEAR

May Be Related to:

Maladaptation of ineffective coping continuing from early life
Unconscious conflict(s); threat to self-concept, threat of death (perceived or actual)
Unmet needs
Phobic stimulus

Possibly Evidenced by:

Increased tension; apprehension, fright; restlessness
Feelings of inadequacy; focus on self or projection of personal perceptions onto the environment
Verbalized focus of fear, e.g., fear of “going crazy”
Maladaptive response to stress (dissociating self/fragmentation of the personality)
Sympathetic stimulation: cardiovascular excitation, superficial vasoconstriction, pupil dilation

Desired Outcomes/Evaluation Criteria— Client Will:

Acknowledge and discuss feelings of anxiety and fear.
Identify ways to manage anxiety/fear effectively.
Demonstrate problem-solving skills.
Use resources effectively.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Develop rapport and trust; accept client's verbal expression of feelings/anxieties.

A trusting alliance facilitates early identification of the underlying sources of anxiety and development of an appropriate treatment approach. Learning to turn to trusted others for support helps the client develop healthy methods of dealing with anxiety.

Discuss with the client the availability of assistance in maintaining safety. (Refer to ND: Violence, risk for, directed at self/others.)

Prevents a false assurance of safety, particularly when internal threats to safety may not be readily apparent. Lack of awareness of need/failure to use resources increases the likelihood of isolation and destructive behaviors. **Note:** Expressions of anxiety may represent a very real threat to or from alternate personalities and/or others.

Identify stressor(s) that precipitate severe anxiety. (Refer to ND: Personal Identity disturbance.)

Helps client recognize individual factors precipitating dissociative symptoms (e.g., splitting, fugue, amnesia), which interfere with developments/use of adequate coping skills.

Maintain a neutral approach when confronted by an alternate personality or dissociative state.

Allows essential observation and documentation and promotes a trusting relationship. Also helps the therapist/care provider to avoid consciously or unconsciously promoting fragmentation of the personality. Because dissociative identity disorder has been sensationalized, personnel may be intrigued by manifestations and respond to the client in ways that reinforce the behaviors manifesting the disorder.

Provide support and encouragement during times of depersonalization.

Client experiences fear and anxiety at these times and may fear "going crazy." Acknowledging these feelings will help client deal appropriately with them.

Reduce alterable sources of stress. Provide calm environment; minimize external stimuli. Identify individual causes/precipitators of stress.

Manipulation of the environment to reduce extraneous sources of stress allows the client to recognize and develop skills in managing internal sources of conflict.

Discuss relationship between severe anxiety and depersonalization behaviors.

Awareness of this relationship provides opportunity to define problem, look at options for dealing with stressors in more effective ways.

Explore past experiences and painful situations (e.g., trauma, abuse) that may be repressed.

Traumatic experiences/patterns of behavior may predispose individuals to dissociative disorders.

Provide positive reinforcement and expectations. Role-model desired behaviors.

This client is commonly very suggestible and responsive to the positive expectations and attention of trusted others. Development of healthy coping mechanisms helps in reducing anxiety.

Prepare client for any testing procedures; provide information about the reason for the test and what is to be expected from the results.

Review test results as indicated.

Observe for/review with client untoward effects/ adverse reaction to medication regimen. Monitor level of alertness, vital signs; note urinary retention, dry mouth, blurred vision, parkinson-like symptoms, rigidity, or atypical response (excitability, restlessness, agitation).

Collaborative

Coordinate and develop a combined treatment plan. Facilitate communication among team members.

Administer antianxiety medications as indicated, e.g., alprazolam (Xanax), diazepam (Valium).

An explanation of the processes of each test can allay anxiety. Care needs to be taken that the physical assessment is presented as routine because the client may misperceive the test as indicative of the presence of a physical disorder and may be prone to a psychosomatic or conversion disorder.

Receiving the results in a timely manner relieves antianxiety. Once organic causes have been ruled out, it is unlikely that extensive examinations and/or testing will have to be repeated, reducing the likelihood that the client might adopt physical symptoms, providing secondary gain.

Psychoactive medications (sedatives, antianxiety/ antipsychotic agents, and antidepressants) frequently produce hypotension and anticholinergic and extrapyramidal symptoms, in addition to the desired effect. Early intervention will alleviate prolonged difficulties and/or serious physical complications and may prevent/lessen anxiety about their presence.

These clients do better when dealing with one primary provider supported by a cohesive treatment team. Therefore, it is essential that all members of the treatment team work together in planning care to ensure that goals and objectives are in agreement and continuity of care exists. Because these clients are prone to manipulative behaviors and may be resistant to therapy, a coordinated treatment plan prevents dissension between disciplines.

Antianxiety medications are given with caution for brief periods to allay panic states or disabling anxiety. Caution is essential, as substance abuse is a common complication and also because of the potential for self-destructive behavior.

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

Psychological conflict; severe level of repressed anxiety
Pattern of trauma/abuse; threat to physical integrity/self-concept

Memory loss/deficit—inability to recall selected events related to a stressful situation, inability to recall events associated with entire life, inability to recall own identity; disorientation

Verbalize understanding that loss of memory is related to stress.

Begin discussing stressful situation(s).

Recover deficits in memory.

Develop more adaptive coping mechanisms to deal with life stressors.

ACTIONS/INTERVENTIONS**RATIONALE**

Independent

Determine degree/extent of memory deficits.
Obtain information about client from family/SO, identifying likes, dislikes, important people, activities, music, pets, etc.

Expose client to stimuli that represent pleasant experiences from the past, such as smells associated with enjoyable activities and music known to be pleasurable.

Avoid flooding client with data about past life.

Engage in further activities that stimulate life experiences as memory returns.

Encourage client to discuss situations that have been especially stressful and to explore the feelings associated with those times.

Explore more adaptive ways to respond to anxiety.

Incorporating information about past may aid client in recovering memories.

Providing pleasurable stimuli can lead client to remembering the past without risk of sudden trauma.

May expose client to painful information from which the amnesia is providing protection. Client may decompensate even further into a psychotic state if recall is too rapid.

Supports continued recall in a nonthreatening manner.

Verbalization of feelings in nonthreatening environment may help client come to terms with unresolved issues that may be contributing to the dissociative process.

Dissociative behaviors will no longer be needed when more effective responses are used.

Collaborative

Administer medication as indicated, e.g.: methylphenidate (Ritalin), pemoline (Cylert), bupropion (Wellbutrin).

Prepare for/assist with IV amobarbital (Amytal) therapy.

Anecdotal information suggests that use of agents that increase synaptic levels of dopamine may be beneficial in treating depersonalization disorder when the client is distressed by persistent symptoms.

May help client regain memory in amnesic or fugue state.

NURSING DIAGNOSIS

May Be Related to:

Possibly Evidenced by:

Desired Outcomes/Evaluation Criteria— Client Will:

COPING, INDIVIDUAL, ineffective

Personal vulnerability; unmet expectations; inadequate support systems/coping methods

Multiple stressors/recurrent, overwhelming trauma to the client, usually occurring in the family of origin

Verbalization of inability to cope/problem-solve

Inappropriate use of defense mechanisms (dissociative states)

Reports of chronic worry, anxiety, depression, poor self-esteem

Inability to meet role expectations; divorce and alienation

Identify ineffective coping behaviors and consequences that are creating problems for the client.

Meet psychological needs as evidenced by appropriate expression of feelings, identification of options, and use of resources.

Demonstrate positive coping mechanisms.

ACTIONS/INTERVENTIONS

Independent

Discuss measures being taken to protect client. Stay with client as needed.

Commit to long-term alliance. Contract with client to refrain from acting on destructive thoughts or ending therapy abruptly. (Refer to ND: Violence, risk for, directed at self/others.)

RATIONALE

Reassures client of psychological safety/security when dissociative behaviors and/or therapy are frightening to the client. Presence of a trusted person can provide sense of security.

These clients often have difficulty developing a therapeutic relationship. Because of high incidence of childhood abuse, client mistrusts authority and has a lifelong habit of “keeping secrets” from self and others.

Encourage discussion and verbalization of stressful situation and exploration of feelings associated with those times. Help client to understand that disequilibrium is to be expected, is understandable, and will resolve as integration occurs.

Demonstrate acceptance during disclosure of painful experiences.

Have client identify methods of coping with stress in the past, the purpose served, and consequences. Determine whether the response was adaptive or maladaptive.

Remain alert to possibility of substance use.

Assist the client to explore alternative coping strategies, evaluating benefits and consequences of each.

Reinforce positive coping techniques.

Provide supportive, insight-oriented therapy; encourage expression of feelings; accept verbal expressions without judgment; encourage recognition of strengths, positive attributes, and progress toward wellness.

Discuss problems of discouragement with slow progress/resolution of problems.

Identify specific conflicts that remain unresolved and problem-solve possible solutions.

Ventilation in a nonthreatening environment may help the client to come to terms with issues that may be contributing to the dissociative process. Provides opportunity for client to relive traumatic experiences, purge associated feelings, and accept the memories.

Fear of condemnation and criticism makes such disclosure difficult, even in a trusting relationship, and support provides reassurance that information will be treated tactfully.

As anxiety decreases, client can begin to develop insight into the appropriateness of the response and develop a plan of action for the future. It is important for the client to understand and accept that the dissociative behavior was originally adaptive and allowed the individual to survive an intolerable situation.

A significant percentage of these clients use substances, such as alcohol, as a means of numbing feelings/coping with psychic pain. This can cloud symptomatology and interfere with progress.

Helps the client to learn new ways to problem-solve and make decisions, which will promote development of independence and use of adaptive coping skills.

Promotes repetition of adaptive behaviors. These clients are very responsive to positive attention.

Dissociative symptoms arise from internal conflict. The behaviors protect the client from psychic pain. Subsequently, any stressor can precipitate a like reaction. Insight-oriented therapy in a supportive setting allows the client to confront and resolve past and present painful or fear-inducing events.

Discouraged feelings are inevitable (in face of treatment that may last for years), and client may resort to old, maladaptive coping mechanisms and feel like giving up. (Refer to ND: Violence, risk for, directed at self/others.)

When these underlying conflicts are not resolved, any improvement in coping behaviors may be regarded as temporary.

Collaborative

Assist client to develop a network of support systems through family, friends, community resources, school/work and church affiliations, as well as health and mental healthcare providers and internal resources.

The tendency to overdependency present in these individuals is antitherapeutic and draining to family, friends, and therapy providers. Development of a large support network and internal resources promotes autonomy.

NURSING DIAGNOSIS

Risk Factors May Include:

[Possible Indicators:]

Desired Outcomes/Evaluation Criteria—

Client Will:

VIOLENCE, risk for, directed at self/others

Dissociative state/conflicting personalities

Depressed mood

Panic states

Suicidal behaviors

Increased motor activity, pacing, excitement, irritability, agitation

Self-destructive behaviors, active aggressive suicidal acts/threats; “internal homicide” (in which one personality attempts to kill another personality)

Substance abuse

Verbalize understanding of why behavior occurs.

Demonstrate self-control as evidenced by relaxed posture, nonviolent behavior.

Express increased self-esteem and meet needs in an assertive manner.

Use resources and support systems effectively.

ACTIONS/INTERVENTIONS

Independent

Remain vigilant to behavioral changes that may signal destructive actions. Assess seriousness of suicidal tendency, gestures, threats, or previous attempts. (Use scale of 1–10 and prioritize according to severity of threat, availability of means.)

Structure the environment to reduce stressors, and remove dangerous objects.

RATIONALE

Client behavior may change abruptly and dramatically. Impulse control may be impaired. (May be no. 1 nursing diagnosis if score is high.)

Minimizing environmental stimuli to provide calm surroundings may prevent escalation/occurrence of violence.

Help client identify/recognize precipitants to destructive behaviors. Discuss ways to reduce exposure to external stressors such as avoidance when practical.

Active-listen, and encourage the client to seek restraint and/or support, when self-destructive or violent impulses are present.

Arrange protection in presence of multiple personalities for "individual" who is prone to violent behavior. Appoint another personality, usually the primary one, to monitor/control the behavior of the suspect personality.

Assist client to identify alternatives to aggression or self-destructive behaviors (e.g., verbal expression, physical activity, written expression).

Take immediate and decisive action when danger is imminent. Tell client to STOP and/or hold as necessary until client calms down.

Encourage participation in exercise program/physical activities.

Note presence/degree of depression and reassess periodically, noting suicidal ideation.

Collaborative

Hospitalize as necessary in inpatient/acute care psychiatric facility.

Place in isolation and provide physical restraint in a nonpunitive manner. Observe closely/stay with client.

Administer antianxiety/antidepressant medication as indicated.

Permits the client to recognize personally distressing factors, promoting early detection and timely intervention. Allows environmental manipulation to reduce the occurrence of disruptive/injurious behaviors.

A therapeutic alliance promotes client responsibility for behavioral restraint while supplementing internal controls. Ventilation can reduce the need for action.

Usually one personality can be identified as having these behaviors, and use of another personality may keep the violence from occurring.

Provides a substitute activity in response to overwhelming impulse to enable client to respond to impulses in a nondestructive manner.

The organized approach of a concerned response by caregivers allows for rapid resolution and minimizes potential for injury to the client/staff/others.

Promotes safe and effective way of relieving tension. Enhances sense of general well-being.
Note: Exercise therapy does not need to be aerobic or intensive to achieve desired effect.

Client may become discouraged and depressed, as treatment is a long-term process, possibly in excess of 10 years.

Usually instituted for differential diagnosis, in response to self-destructive thoughts/behavior, violence or potential violence, and/or psychosomatic complaints or conversion reaction.

Punishment has no therapeutic value, but external controls are necessary to ensure safety/provide reassurance to client when internal controls fail. Close observation following initial restraint will be necessary to assure the effectiveness of the restraints and that the client is not injured by the restraint (e.g., impaired circulation, aspiration, suffocation, strangulation).

May be required to reduce anxiety until internal controls are achieved and/or elevate mood to allow client to begin to deal with feelings/situation.

NURSING DIAGNOSIS**PERSONAL IDENTITY disturbance****May Be Related to:**

Psychological conflicts (dissociative state[s])
Threat to physical integrity/self-concept; pattern of childhood trauma/abuse
Underdeveloped ego

Possibly Evidenced by:

Memory loss (unable to recall selected events/own identity); presence of more than one personality within the individual
Confusion about sense of self, purpose or direction in life; alteration in preception or experience of the self
Loss of one's own sense of reality/the external world; poorly differentiated ego boundaries

Desired Outcomes/Evaluation Criteria—

Acknowledge threat to personal identity.

Client Will:

Engage in a therapeutic alliance.

Integrate threat in a healthy, positive manner (e.g., make commitment to long-term therapy, state anxiety is manageable, make plans for future).

**Client With Dissociative Identity Disorder
(in addition to above)**

Verbalize awareness of all personalities, their thoughts and behaviors (development of co-consciousness).

Display cooperation among the personalities.

Demonstrate more stable personalities with resolution of traumatic events, moving toward partial to full integration into one personality.

Verbalize acceptance of positive feelings toward emerging personality.

ACTIONS/INTERVENTIONS**RATIONALE**

Independent

Develop trusting relationship with individual (and "alters" or subpersonalities if present).

Trust is the basis of a therapeutic relationship, but it may be difficult to achieve as client is often demoralized and suspicious, believing life is unjust/hopeless, or even that she or he is evil. In dissociative identity disorder, each of the personalities views itself as a separate entity and must initially be treated as such.

Determine client's perception of the extent of the threat of self-integrity and current response.

Help client understand/accept reality of the disorder (e.g., other personalities) and meaning of lapses in memory.

Ascertain what client does recall and compare with information obtained from family members/other personalities.

Share information in small amounts over a period of time. Avoid giving too much information (flooding) at any one time.

Facilitate identification of stressful situations that precipitate dissociative state/transition from one personality to another. (Refer to ND: Coping, Individual, ineffective.)

Encourage client to identify the need the behavior/each subpersonality serves in the overall identity of the individual.

Provide psychotherapy with feedback relative to behavioral observations. Encourage journal-keeping (therapeutic writing) and other methods designed to allow gradual insight.

Discuss integration of the subpersonalities into a unified identity within the individual and help client understand that all personalities will contribute to the whole.

Collaborative

Plan use of confrontive methods with all team members. Use cautiously.

Use/assist with hypnosis as indicated.

Degree of distress perceived by the client will assist in determining therapeutic interventions.

May be unaware/lack understanding of condition, resulting in increased anxiety and confusion about self.

Helps in orienting to realities of past events and assists client toward memory integration.

Enables client to begin to deal with painful information for which the amnesia has provided protection in the past. Too much material at any one time can be difficult for client to handle, increasing risk of decompensation.

Assists client to respond more adaptively and to eliminate the need for separation from self.

Knowledge of these unfulfilled needs enables client to face unresolved issues without dissociation and is the first step toward integration of multiple personalities.

Decreases denial and amnesia, providing an opportunity for client to accept the presence of the disorder and begin to "own" behaviors/personality components. Acceptance and ownership assist the client in cooperating as a unified identity and with subsequent integration when multiple personalities are present.

The idea of total elimination generates fear and defensiveness within alters who function as separate entities.

These methods need to be paced with the individual's ability to benefit therapeutically and planned within the team conference to avoid oversteering the individual and precipitating exacerbation or decompensation.

Allows client to become familiar with dissociation and learn how to interrupt/control it. Provides opportunity for client to make traumatic memories/feelings conscious and realize this will not destroy them. May be used to gain access to multiple personalities, helping client to work through and accept realities of positive aspects of each personality and participate in rituals of joining/integration.

Engage in activities that reflect life experiences, using occupational/vocational/recreational/physical therapy. Begin with pleasurable stimuli (as identified by the client), e.g., events, smells, pets, or music associated with pleasurable activities.

Presents additional stimulation, which may encourage recall of repressed material. Provides opportunity to experience positive feelings that have also been repressed and to work toward beginning to deal with negative feelings/occurrences.

NURSING DIAGNOSIS

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

Multiple stressors, repeated over period of time

Temporary family disorganization and role changes; prolonged progression of disorder that exhausts the supportive capacity of significant people

Significant person with chronically unexpressed feelings of guilt, anger, hostility, and so forth

High-risk family situation (e.g., recurrent episodes of neglect/abuse, substance abuse)

Possibly Evidenced by:

Significant person describes inadequate understanding or knowledge base that interferes with effective assistive or supportive behaviors

Expresses despair regarding family reactions/lack of involvement

Marital conflict (separation/divorce)

Neglectful care of client in regard to basic human needs; intolerance, abandonment, rejection, desertion

Distortion of reality regarding the client's health problem, including extreme denial about its existence or severity

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

Verbalize more realistic understanding and expectations of the client.

Identify/verbalize resources within individual members to deal with the situation.

Provide opportunity for client to deal with situation in own way.

Remain intact, or separate in healthy way, being supportive of the client and one another.

ACTIONS/INTERVENTIONS

RATIONALE**Independent**

Identify contributing factors within the family or environment.

Family and marital dysfunction are extremely likely to occur. These factors contribute to ongoing emotional stress for all family members.

Note family members who are involved with client, e.g., by marriage (husband, children), family of origin (mother/father, siblings, extended family). Complete a genogram.

Provide client/family education relative to the disorder and treatment plan.

Explore family dynamics. Note denial, enabling/sabotage behaviors (e.g., denying existence of problems, failure to attend therapy/keeping client from attending).

Provide for client safety within the family setting or arrange for alternative living arrangements if abuse or neglect is an issue. (Refer to CP: Parenting, regarding issues of current abuse/neglect.)

Help family respond to client in a manner that reinforces positive behaviors.

Encourage the family to ventilate negative feelings and continue as much as possible with usual daily activities. Discourage family from allowing client to escape responsibilities because of the illness.

Collaborative

Refer for additional individual, family, or marriage counseling.

It is important that all willing family members interacting with client be involved in helping with the therapeutic regimen, to allow for the best possible outcome for client.

Understanding of problem and that the disorder can be treated reduces anxiety, frustration, and guilt and lets client progress within a supportive environment.

Other family members may be invested in keeping the “sick” member symptomatic in order to camouflage their own problems.

If client remains in family of origin, a diagnosis of dissociative state/dissociative identity disorder should alert personnel to the possibility of abuse/neglect. As the “responsible adult,” client may be unable to meet needs of own child(ren)/family.

Without assistance, the family may provide secondary gain for client’s continued illness instead of promoting wellness.

Family members are less likely to abandon the affected member if they have an outlet for anger/frustration and are not overburdened in caretaking. Positive expectations from family members promote hope for recovery, enhance self-esteem, and decrease the likelihood of secondary gain.

Concurrent psychiatric problems in other family members are common. If client’s symptoms are the most florid, that individual has likely been identified as the “sick” family member and others have not sought/received help.