

# **PROBLEMS RELATED TO ABUSE OR NEGLECT**

## **DSM-IV**

### **IF FOCUS OF ATTENTION IS ON THE VICTIM [SURVIVOR]:**

995.52 Neglect of child

995.53 Sexual abuse of child

995.54 Physical abuse of child

995.81 Physical abuse of adult

995.83 Sexual abuse of adult

### **IF FOCUS OF ATTENTION IS ON THE PERPETRATOR [OFFENDER] OR ON THE RELATIONAL UNIT IN WHICH BEHAVIOR OCCURS:**

V61.21 Neglect; physical or sexual abuse of child (specify)

V61.12 (Physical or sexual abuse of adult by partner)

V62.83 (Physical or sexual abuse of adult by person other than partner)

Abuse affects all populations and is not restricted to specific socioeconomic or ethnic/cultural groups. Although “violence” means the use of force or physical compulsion to abuse or damage, the term “abuse” is much broader and includes physical or mental maltreatment and neglect that result in emotional, physical, or sexual injury. In the case of children, the disabled, or elderly, abuse can result from direct actions or omissions by those responsible for the individual’s care. Additionally, one’s perception of abuse is affected by cultural and religious practices, values, and biological predispositions. The problem can be generational, with victimizers often being victims of abuse themselves as children.

Violence is not a new problem; in fact, it is probably as old as humankind. However, in the United States, medicine has focused on these issues only since 1946. Therefore, the parameters of abuse are being identified and redefined on what seems to be an almost daily basis. For example, until recently women and children were considered the personal property of men and they did not own property or have rights of their own. Women viewed themselves as sexual objects and were expected to subjugate themselves/defer to the will of men. Harsh treatment of children was justified by the belief that corporal and/or excessive punishment was necessary to maintain discipline and instill values. Changes in societal beliefs and the enactment of new laws have done little to curb abuse. Today, battering is the single most common cause of injury to women, and there has been an increase in the incidence of child abuse and neglect-related fatalities reported to child protection service agencies in the United States. Whether these statistics represent an increase in incidents or are the result of changing attitudes and/or better reporting is much debated. The Centers for Disease Control and Prevention has declared violence to be a public health problem.

This plan of care addresses the problems of abuse and neglect in both adults and children and includes both the person who offends and the survivor of the offense.

## **ETIOLOGICAL THEORIES**

### **Psychodynamics**

Psychoanalytical theory suggests that unmet needs for satisfaction and security result in an underdeveloped ego and a poor self-concept in the individuals involved in violent episodes. Aggression and violence supply the offender with a sense of power and prestige that boosts the self-image and provides a significance or purpose to the individual’s life that is lacking. Some theorists have supported the hypothesis that aggression and violence are the overt expressions of powerlessness and low self-esteem. The same dynamics promote acceptance in the person who is the victim of violence.

## **Biological**

Various components of the neurological system have been implicated in both the facilitation and inhibition of aggressive impulses. The limbic system in particular appears to be involved. In addition, higher brain centers play an important role by constantly interacting with the aggression centers. Various neurotransmitters, such as epinephrine, norepinephrine, dopamine, acetylcholine, and serotonin, may also play a role in facilitation and inhibition of aggressive impulses. This theory is consistent with the “fight-or-flight” arousal in response to stress.

Some studies suggest the possibility of a direct genetic link; however, the evidence for this has not been firmly established. Organic brain syndromes associated with various cerebral disorders have been linked to violent behavior. Particularly, areas of the limbic system and temporal lobes, brain trauma, and diseases such as encephalitis and disorders such as epilepsy have been implicated in aggressive behavior.

## **Family Dynamics**

Child abuse is often the consequence of the interactions of parental vulnerabilities (e.g., mental illness, substance abuse); child vulnerabilities (e.g., low birth weight, difficult temperament); a particular developmental stage, such as toddler, adolescence; and social stressors (e.g., lack of social supports, young parental age, single parenthood, poverty, minority ethnicity, lack of acculturation, exposure to family violence).

Learning theory states that children learn to behave by imitating their role models, usually parents, although as they mature they are influenced by teachers, friends, and others. Individuals who were abused as children or whose parents disciplined them with physical punishment are more likely to behave in a violent manner as adults. Television and movies are believed to have an influence on developing both adaptive and maladaptive behavior. Some theorists believe that individuals who have a biological influence toward aggressive behavior are more likely to be affected by external models than those without this predisposition.

The influence of culture and social structure cannot be discounted. Difficulty in negotiating interpersonal conflict has led to a general acceptance of violence as a means of solving problems. When individuals/groups of people discover they cannot meet their needs through conventional methods, they are more likely to resort to delinquent behaviors. This may contribute to a subculture of violence within society.

## **CLIENT ASSESSMENT DATA BASE**

### **Activity/Rest**

Sleep problems (e.g., sleeplessness or oversleeping, nightmares, sleepwalking, sleeping in strange place  
[avoiding offender])

Fatigue

### **Ego Integrity**

Negative self-appraisal, acceptance of self-blame/making excuses for the actions of others

Low self-esteem (offender/survivor)

Feelings of guilt, anger, fear and shame, helplessness, and/or powerlessness

Minimization or denial of significance of behaviors (most prominent defense mechanism)

Avoidance or fear of certain people, places, objects; submissive, fearful manner (particularly in presence of offender)

Report of stress factors (e.g., family unemployment; financial, lifestyle changes; marital discord)

Hostility toward/mistrust of others

Threatened when partner shows signs of independence or shares self/time with others (offender)

## **Elimination**

Enuresis, encopresis  
Recurrent urinary infections  
Changes in tone of sphincter

## **Food/Fluid**

Frequent vomiting; changes in appetite: anorexia, overeating (survivor)  
Changes in weight; failure to gain weight appropriately/signs of malnutrition, repeated pica (neglect)

## **Hygiene**

Wearing clothing that covers body in a manner inappropriate for weather conditions (abuse), or that is inadequate to provide protection (neglect)  
Excessive/anxiety about bathing (abuse); dirty/unkept appearance (neglect)

## **Neurosensory**

Behavioral extremes (very aggressive/demanding conduct); extreme rage or passivity and withdrawal; age-inappropriate behavior

### **Mental Status:**

**Memory:** Blackouts, periods of amnesia; reports of flashbacks  
Disorganized thinking; difficulty concentrating/making decisions  
Inappropriate affect; may be hypervigilant, anxious, depressed

Mood swing—"dual personality," extremely loving, kind, contrite after battering episode (offender)

Pathological jealousy; poor impulse control; limited coping skills; lacks empathy (offender)

Rocking, thumb sucking, or other habitual behavior; restlessness (survivor)

Psychiatric manifestations (e.g., dissociative phenomena including multiple personalities (sexual abuse); borderline personality disorder [adult incest survivors])

Presence of neurological deficits/CNS damage without external injuries evident (may indicate "shaken baby" syndrome)

## **Pain/Discomfort**

Dependent on specific injuries/form of abuse  
Multiple somatic complaints (e.g., stomach pain, chronic pelvic pain, spastic colon, headache)

## **Safety**

Bruises, bite marks, skin welts, burns (e.g., scalding, cigarette), bald spots, lacerations, unusual bleeding, rashes/itching in the genital area; anal fissures, skin tags, hemorrhoids, scar tissue, changes in tone of sphincter

Recurrent injuries; history of multiple accidents, fractures/internal injuries

Description of incident incongruent with injury, delay in seeking treatment

Lack of age-appropriate supervision, inattention to avoidable hazards in the home (neglect)

Intense episodes of rage directed at self or others

Self-injurious/suicidal behavior; involvement in high-risk activities

History of suicidal behavior of family members

## Sexuality

Changes in sexual awareness or activity, including compulsive masturbation, precocious sex play, tendency to repeat or reenact incest/abuse experience; excessive curiosity about sex; sexually abusing another child; promiscuity; overly anxious/inhibited about sexual anatomy or behavior

May display feminine sex-role stereotypes; confusion about sexuality (male survivors); may have unconscious homosexual tendencies (male offenders of incest)

Reports of decreased sexual desire (as adult), erectile dysfunction, premature ejaculation, and/or anorgasmia; dyspareunia, vaginismus; flashbacks during intercourse; inability to engage in sex without anxiety

Episodes of marital rape or forced intercourse

Impaired sexual relationship between parents (incest)

Parent/female careprovider aware or strongly suspects incestual behavior, may be grateful not to be focus of partner's sexual demands

Obstetrical history of preterm labor, abruptio placentae, spontaneous abortions, low birth weight, fetal injury/death (1 in 6 pregnant women are battered during pregnancy); lack of prenatal care until 3rd trimester (abused women twice as likely to delay care)

Vaginal bleeding; linear laceration of hymen, vaginal mucosa

Presence of STDs, vaginitis, genital warts, or pregnancy (especially child)

## Social Interactions

Multiple family/relationship stressors reported

Household members may include step-relatives or a paramour

History of frequent moves/relocation

Few/no support systems

Lacks knowledge of appropriate child-rearing practices (child abusers)

Inability to form satisfactory peer relationships; withdrawal in social settings; inappropriate attachment to imaginary companion

Very possessive, perceives partner as a possession; repeatedly insults/humiliates partner, strives to isolate partner from others/keeps partner totally dependent, challenges partner's honesty, uses intimidation to achieve power/control over partner (offender)

Lack of assertive communication skills; difficulty negotiating interpersonal conflicts

Cheating, lying; low achievement or drop in school performance

Running away from home/relationship

Parent may interfere with child's normal peer relationships to prevent exposure (incest)

Memories of childhood may contain blank periods, excessive fantasizing/daydreaming; report of violence/neglect in family of origin

**Family Interaction Pattern:** Less verbally responsive, increased use of direct commands and critical statements, decreased verbal praise or acknowledgment, belittling, denigrating, scapegoating, ignoring; significant imbalance of power/use of hitting as control measure, patterns of enmeshment, closed family system; one parent domineering, impulsive; other partner passive, submissive

## Teaching/Learning

May be any age, race, religion/culture, or educational level; from all socioeconomic groups (usual child profile is under age 3 or perceived as different due to temperamental traits, congenital abnormalities, chronic illness)

Learning disabilities include attention-deficit disorders, conduct disorders

Delay in achieving developmental tasks, declines on cognitive testing; brain damage, habitual truancy/absence from school for nonlegitimate reasons (neglect)

Substance abuse by individuals involved in abuse/neglect, or other family member(s) (most often cocaine, crack, amphetamines, alcohol)

Use of multiple healthcare providers/resources (limits awareness of repeated nature of problem); lack of age-appropriate health screening/immunization, dental care, absence of necessary prostheses, such as eyeglasses, hearing aid (neglect)

## DIAGNOSTIC STUDIES

### Physical and Psychological Testing

Dependent on individual situation/needs

**Screening Tests (e.g., Child Behavior Checklist):** Elevated scores on the internalization scale reveal behaviors described as fearful, inhibited, depressed, overcontrolled or undercontrolled, aggressive, antisocial.

## NURSING PRIORITIES

1. Provide physical/emotional safety.
2. Develop a trusting therapeutic relationship.
3. Enhance sense of self-esteem.
4. Improve problem-solving ability.
5. Involve family/partner in therapeutic program.

## DISCHARGE GOALS

1. Physical/emotional safety maintained.
2. Trusting relationship with one person established.
3. Self-growth and positive approaches to problems evident.
4. Client/SOs participating in ongoing therapy.
5. Plan in place to meet needs after discharge.

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### NURSING DIAGNOSIS

#### Risk Factors May Include:

#### Possibly Evidenced by:

#### Desired Outcomes/Evaluation Criteria—

#### Client Will:

#### Client/Family Will:

### TRAUMA, risk for

Dependent position in relationship(s)

History of previous abuse/neglect

Lack or nonuse of support systems/resources

[Not applicable; presence of signs and symptoms establishes an *actual* diagnosis.]

Be free of injury/signs of neglect.

Recognize need for/seek assistance to prevent abuse.

Identify and access resources to assist in promoting a safe environment.

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## **ACTIONS/INTERVENTIONS**

## **RATIONALE**

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### **Independent**

Note age/developmental level of survivor, mentation, agility, physical abilities/limitations.

Children under 3, those perceived as having different temperament, or those with congenital problems /chronic illness are at increased risk of being abused/neglected. Additionally, the elderly who are dependent on others because of age/ infirmities or individuals with significant disabilities are also at risk. Those who are incapable of meeting their own needs/directing their personal affairs may require alternate placement/court-ordered advocate.

Review physical complaints/injuries including those that suggest possibility of sexual abuse (e.g., bladder infection, bruises in the genital area, reports of aggression or inappropriate sexual behavior). Note affect and demeanor.

The visible evidence of physical abuse/neglect makes it more easily recognized. Although these clients display signs of emotional involvement, inappropriate affect, and behaviors such as withdrawal, acting out, or suicidal gestures in the absence of physical evidence of abuse/neglect, suggests presence of emotional abuse. Child sexual abuse is particularly difficult to diagnose. Although the signs noted here are not definitive, they suggest need for further investigation.

Identify individual concerns of client.

Concerns will vary dependent on individual circumstances and affect choice of interventions, possible options.

Interview offender(s)/family in a nonjudgmental manner, displaying tact and professional concern for individual(s).

Can provide insight into risks to client and potential for repetition of behavior. The need for power over or control of survivor, excessive jealousy/overpossessiveness, frequency of verbal arguments that can escalate to violence, substance abuse, severity of past injuries inflicted, history of forced or threatened sexual acts, and/or threats to kill client (especially when offender indicates a belief he or she cannot live without partner) greatly increases the level of concern for survivor's safety and choice of interventions.

Maintain objectivity and avoid blame or accusations during interview process.

Individuals will be defensive and may react with hostility and anger, or may withdraw, making it difficult to obtain accurate information. Initially, offender may not be known, and even if family is not involved in situation, members may feel guilt that they did not protect the survivor. Avoiding blame promotes open communication and therapeutic interactions and may enhance the investigation process.

Use open-ended questions with gentle, caring manner. Speak at individual's level (e.g., child vs. adult, or developmentally disabled individual). Provide privacy as indicated by age, circumstances of the situation.

Use techniques of play therapy to obtain information from children. Videotape session(s) as appropriate.

Note sequence of events as related by parent(s)/caregivers or partner, paying particular attention to inconsistencies and contradictory reports.

Evaluate family and home environment. Note particularly areas of stress related to abusive occurrence.

Identify individual risk factors for recidivism of abuse/neglect.

Help adult survivor develop a safety plan incorporating available personal and community resources.

Survivor and parent/family members will respond more positively to caring approach and be more available for help to correct underlying problems when dealt with in this way. **Note:** Care must be taken to avoid leading the child survivor, or suggesting answers to questions. As these individuals are vulnerable, they are suggestible and may provide answers to "please" the therapist, resulting in questionable information.

The child may be afraid to tell/be unable to adequately verbalize what has happened. Play therapy is a nonthreatening method of observation/Active-listening that allows for free expression of the child's feelings and perceptions without undue influence from adults. Videotaping allows various parties (legal and counseling) to view the same data, reducing risk of misinterpretation and negating need for child to submit to repeated questioning, which may color data over time. In addition, this can provide safeguards for both therapist and survivor.

May reveal reality of what happened. Offender(s)/family members are upset and afraid about what has happened/the potential consequences and may try to cover up circumstances of injury.

Provides clues to need for change to prevent further problems. Families who move their residence frequently and are socially isolated, and stepfamilies are at greater risk. Children who have been separated from parents because of prematurity or neonatal illness also may be more at risk, owing in part to problems with bonding and situational stressors (e.g., financial concerns, demands of caregiving role).

Offender's resistance to ongoing therapy, substance abuse, immaturity, and narcissistic personality traits increase risk that violent behavior will recur.

Typically, these individuals have few/are separated from support systems and require assistance to identify options and initiate a plan. Additionally, availability of resources such as women's shelters, counseling services, or ombudsman for the elderly/disabled varies according to locality.

Discuss importance of involved adults participating in therapeutic program. Identify consequences of abusive behaviors.

Without outside intervention, the behavior is likely to continue. Loss of family (divorce, separation, restraining order, alternate placement), loss of property/income, possible loss of job, as well as potential for incarceration can occur. Studies indicate skilled specialized counseling has a success rate of 50%–75% in eliminating violent behavior.

### **Collaborative**

Follow correct procedures and be familiar with reporting protocols of institution/community.

Legal obligations vary from state to state, but most states have mandatory reporting of suspected child abuse and some have added mandatory reporting for adults as well. Sensitive handling of this procedure can provide protection for the client and direct families to the help they need to promote improved functioning.

Arrange for home-based interventions (e.g., visiting nurse, First Visitor, Bright Beginnings) as indicated.

Home visitation/support provides opportunity for teaching/modeling of effective child rearing behaviors, ongoing monitoring of home situation, and early identification of/intervention for developing problems to help maintain the family unit.

Refer to individual/family therapy.

As in the case of violent behavior, involved individuals need to distinguish between validity of emotions and the inappropriateness of behavior. Violence is the choice of the offender, is under his or her control, and is his or her sole responsibility although the dynamics of relationship(s) may be a factor.

Refer individuals to substance abuse program, as appropriate.

Substance abuse has a negative impact on the therapeutic process and increases likelihood that behavior will recur/continue.

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### **NURSING DIAGNOSIS**

#### **May Be Related to:**

#### **Possibly Evidenced by:**

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### **SELF ESTEEM, chronic low**

Personal vulnerability, feelings of abandonment, circular process of self-negation

Life choices perpetuating failure/abuse

Self-negating verbalization, expressions of shame/guilt

Evaluating self as unable to deal with events

Rationalizing away/rejecting positive feedback and exaggerating negative feedback about self

Hesitancy to try new things/situations; nonassertive/passive, indecisive, or overly conforming behaviors

**Desired Outcomes/Evaluation Criteria—**

**Client Will:**

Verbalize understanding of negative evaluation of self and reasons for this problem.

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.

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**ACTIONS/INTERVENTIONS**

**RATIONALE**

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**Independent**

Develop therapeutic relationship. Be attentive, validate client’s communication, provide encouragement for efforts, maintain open communication, use skills of Active-listening and “I-messages.”

Promotes self-esteem by validating the individual as a worthwhile person who has important things to say and has value in the situation. This relationship may be slow to develop because client’s feelings of betrayal will influence ability to trust others as well as herself or himself. **Note:** Males who have been sexually abused may have difficulty with self-disclosure to male therapists, and young children may fear being seduced by male therapist or be concerned that female therapist will not act in a protective manner.

Note body language and hypervigilant attitude.

After period of testing reliability of caregiver/therapist, client may begin to relax vigilance, indicating initiation of trust relationship and openness to progress in therapy.

Assess content of negative self-talk.

“Damaged goods” syndrome and self-blame for what has occurred are common. Additionally, this may be reinforced by negative responses by individuals/peers, hostility from family members, and inner feelings of shame/guilt. Depending on severity, this will likely be the initial focus of therapy once survivor safety is assured.

Discuss survivor’s perceptions of self related to what is happening. Confront misconceptions.

Client frequently believes she or he is “lacking” or in some way causing the behavior in the other person. Gently confronting these misperceptions can help client accept the reality that she or he is *not* responsible for the other’s behavior.

Emphasize need for client to avoid comparing self to others.

Pattern has been established to make unfavorable comparisons, and stopping this thought process is a step toward increasing client’s self-esteem.

Be aware that people are not programmed to be rational—rather, it is a learned behavior/skill.

Confront client's tendency to minimize situation. Discuss impact of abuse/neglect on individual.

Proceed with caution when helping client recall/investigate areas of life that have been forgotten.

Identify what behavior does for client (positive intention, i.e., maintains dependent position, creates sense of power). Ask what options are available to the client/SO.

Set limits on aggressive or problem behaviors, such as acting out, suicide preoccupation, or rumination. (Refer to ND: Violence, risk for, directed at self/others.)

Discuss inaccuracies in self-perception with client/SO(s). Help client to recognize view of self as "the victim."

Have client list current/past successes and strengths. Provide feedback using positive "I-messages" rather than praise.

Discuss past choices, helping client identify future options. Avoid blaming client; assuring client that his or her decision was the best that could be made at the time.

Help client identify goals that are personally achievable and supportive of self.

In order to develop positive self-esteem, individual needs to seek information/facts, choose to learn, choose to think rather than merely accepting/reacting to what is happening, to respect self and value honesty.

Gentle confrontation can help the client begin to accept the reality of what has happened. Giving up the "fantasy" of "things as you wish they were" provides a stronger base for client to build on, enhancing likelihood of successful outcome.

While the concept of repression has long been accepted in psychology, the phenomenon of "false memories" has raised questions regarding the validity of what is remembered. The suggestion of questioning and the client's own misperceptions and fantasies can lead to inaccurate conclusions and accusations that may be damaging to the client and family.

Promotes awareness of why things are the way they are and provides a starting point for making changes.

These behaviors diminish self-esteem, and continuation of them interferes with recovery. Rumination locks client into a circular path rather than allowing individual to move forward and "get on" with life.

Client may not see positive aspects of self that others see, and bringing it to awareness may help change perception. Dwelling on/sense of being "the victim" can interfere with sense of worth and impede recovery.

Helps develop internal sense of self-worth, new coping behaviors. The use of praise is external control and may be rejected by the individual.

Negative view of self and perceived lack of options can interfere with client taking control of own life and developing new behaviors to prevent future abusive situations. **Note:** Appropriately attributing responsibility for the abuse to other(s)/accepting responsibility for own actions as appropriate, is an important part of healing, allowing client to stop self-criticism and begin self-nurturing and protection.

Provides direction for client to work toward. **Note:** Clients not only need to feel differently about themselves but also need to treat themselves differently.

Allow client to progress at own rate.

Adaptation to a change in self-concept depends on its significance to individual, disruption of lifestyle, and length of illness/debilitation. **Note:** Emotional abuse (e.g., rejecting, terrorizing, ignoring, isolating, or corrupting) may have continued for a prolonged period of time before being diagnosed and therefore may be more pervasive and more difficult to overcome than physical abuse.

Involve in activities/exercise program.

Provides opportunities to practice new skills and promotes socialization; helps relieve anger/stress and enhance sense of general well-being.

Encourage development of social/vocational skills.

Participation in classes/activities/hobbies that client enjoys or would like to experience promotes successful accomplishments, enhancing self-worth. Also provides options for increased independence and future options.

Give positive reinforcement for progress noted.

Helps client accept self as a worthwhile person. Positive words of encouragement support development of coping behaviors.

Evaluate educational placement.

Special program may be needed to help client overcome educational deficiencies and catch up to appropriate grade level/obtain GED, etc.

Identify family dynamics past and present.

Family interactions contribute to development of self-esteem in family members and provide clues to problems contributing to abuse.

Provide age-/situation-appropriate bibliotherapy.

Reading information supplements and supports other therapeutic intervention.

### **Collaborative**

Provide therapy in a team setting and seek peer consultation as appropriate.

Opportunity for open discussion increases therapist's awareness of personal feelings regarding abuse behavior/victimization of client, overidentifying with client, merging with the criminal justice system's (society's) need for retribution or need to "rescue" client, which could lead to countertransference problems and interfere with the progress of therapy. **Note:** This concern may be of greater significance when survivor is a child who has been sexually abused and the therapist has discomfort regarding own sexuality and unconscious childhood fantasies.

Involve in classes such as assertiveness training, positive self-image, communication skills.

Assists with learning skills to promote self-esteem.

Provide information about available community programs and opportunities for involvement.

Influencing one's community through volunteer or paid service (e.g., abuse prevention programs or as a survivor advocate) allows individual to be proactive and view self as a contributing member of society, aiding in client's own recovery process.

Refer to clinical nurse specialist, psychologist/psychiatrist, group therapy is indicated.

Type, severity, frequency, duration, and age of individual at time of abuse affect recovery. Client may require long-term and/or specialized therapy, such as hypnosis. Additionally, group therapy provides an opportunity for sharing own healing with other survivors/offenders and learn new skills to enhance sense of self-worth.

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**NURSING DIAGNOSIS****POWERLESSNESS****May Be Related to:**

Legitimate dependency on other(s) (child, elderly, disabled individual), personal vulnerability

Interpersonal interaction (e.g., misuse of power, force, abusive relationships)

Lifestyle of helplessness (e.g., repeated failures, dependency)

**Possibly Evidenced by:**

Verbal expressions of having no control

Reluctance to express true feelings, fearing alienation from caregiver(s)

Apathy (withdrawal, resignation, crying), passivity; anger

**Desired Outcomes/Evaluation Criteria—**

Express sense of control over future.

**Client Will:**

Identify areas over which individual has control.

Engage in problem-solving activities.

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**ACTIONS/INTERVENTIONS****RATIONALE****Independent**

Identify circumstances of individual situation contributing to client's sense of powerlessness.

Promotes understanding of factors involved and enables client to begin to develop sense of control over self and future.

Determine client locus of control.

Client who believes problems are caused by others (external) will need to begin to accept own responsibility for being in charge of self. Making a decision to take control of own life is crucial to making changes needed to support growth.

Help client identify factors that are under own control.

Provides a starting point for client to begin to assume control over own life.

Identify use of manipulative behavior and reactions of client, SO(s), and healthcare providers.

Manipulation is used for management of powerlessness because of distrust of others, fear of loss of power/control, fear of intimacy, and search for approval. This can interfere with personal and therapeutic relationships.

Discuss needs openly with client. Set agreed-on routines for meeting identified needs.

Identify when flashbacks are problem for survivor and how they may be minimized.

### **Collaborative**

Refer to assertiveness program.

Promotes meeting needs directly and decreases the need for client to use manipulation.

May occur with fatigue or stress and generally intensify feelings of loss of control. Avoidance of individual “triggers” may reduce occurrence.

As client learns these skills and becomes more active/assertive in relationships, she or he is more likely to set limits on the behaviors of others, express feelings more openly/directly, and take control of own life in a healthy manner.

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### **NURSING DIAGNOSIS**

**May Be Related to:**

**Possibly Evidenced by:**

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

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### **COPING, INDIVIDUAL, ineffective**

Situational/maturational crises

Overwhelming threat to self, personal vulnerability

Inadequate support systems

Verbalization of inability to cope/ask for help

Chronic worry, anxiety, depression, poor self-esteem

Inability to problem-solve, lack of assertive behaviors

Inappropriate use of defense mechanisms (e.g., denial, withdrawal)

High illness rate, destructive behavior toward self/others

Assess the current situation accurately (related to age, individual condition).

Identify ineffective coping behaviors and consequences.

Verbalize feelings congruent with behavior.

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### **ACTIONS/INTERVENTIONS**

#### **Independent**

Help client separate issues of vulnerability from blame.

Active-listen and identify client perceptions/ understanding of current situation. Evaluate decision-making ability.

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### **RATIONALE**

Client blames self/others for situation without looking at own responsibility for victim stance. Although this does not excuse abuse, client needs to change victim behaviors to gain control of self.

Client often enters the healthcare system in response to a crisis. This is an opportunity to help the client look at reality of abuse and begin to make changes.

Identify previous methods of dealing with life problems. Note use of denial.

Encourage verbalization of fears and anxieties and expression of feelings of denial, depression, and anger. Let client know that these are normal reactions.

Encourage and support client in evaluating lifestyle. Assess stressors and make plan for necessary change.

### **Collaborative**

Refer to appropriate resources as indicated by individual situation (e.g., support groups, AA, psychotherapy, spiritual resources).

Provides clues to coping skills that can be used for personal growth. Denial is the most prominent defense mechanism used by client/family members to protect against shame/guilt and to preserve intactness of the family, and it must be dealt with before progress can be made.

Expressing feelings helps client to become aware of the feelings, recognize and deal with what is happening.

Identifying areas of life that promote abusive reactions/interactions helps client make changes in coping methods to prevent recurrences.

May need additional therapy/group involvement to learn new coping skills.

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### **NURSING DIAGNOSIS**

#### **Risk Factors May Include:**

#### **[Possible Indicators:]**

#### **Desired Outcomes/Evaluation Criteria—**

#### **Client Will:**

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### **VIOLENCE, risk for, directed at self or others**

Negative role modeling, developmental crises

History of abuse

Rage reactions; suicidal behavior

Organic brain syndrome; temporal lobe epilepsy

Anger, rage; fear of others

Increasing anxiety level, motor activity

Hostile threatening verbalizations; body language indicating effort to control behavior

Overt and aggressive acts

Expressed intent/desire to harm self/others; self-destructive behaviors, substance abuse

Acknowledge realities of the situation.

Verbalize understanding of why behavior occurs.

Identify precipitating factors/responses.

Demonstrate new skills/methods for dealing with own responses.

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## ACTIONS/INTERVENTIONS

## RATIONALE

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### **Independent**

Determine underlying dynamics of individual situation (e.g., pattern of abuse, contributing factors to violent behavior, relationship of involved persons [parent/child, spouse or lover], family pattern of communication.)

Note signs of suicidal/homicidal intent (e.g., statements of intent/threats, development of a plan, giving away belongings, possession of means).

Determine client's perception of self, impact of abuse on life, and future expectations.

Explore death fantasies when expressed (e.g., "They'll be sorry.").

Note coping behaviors being used currently by the client (e.g., denial, helplessness, rage reaction).

Acknowledge reality of suicide/homicide as an option. Discuss consequences of actions if individual were to follow through on intent. Ask how it will help client resolve problems.

Encourage appropriate expression of feelings. Acknowledge reality and normalcy of these feelings. Set limits on acting-out behaviors.

Accept client's anger without reacting on an emotional basis.

Contract with client for safety.

Necessary to determine needs/safety concerns.

Allows for initiation of safety measures to protect client/others. **Note:** Association between suicidal behavior and physical abuse may be related to modeling of aggressive behavior within family/exposure to suicidal behavior of family member(s) as well as biological risk in family for disorders associated with suicide (e.g., substance abuse and affective or impulsive conduct disorders).

May see self as useless, damaged goods without hope for positive change/productive future, which may result in feelings of hopelessness and the perception of lacking options. Depth of rage and extent of feelings of powerlessness may predict potential for violent behavior.

Discussion of fantasies helps client look at reality of ideas and begin to deal with them.

Provides information about mechanisms client uses to maintain the status quo, which may also increase risk for violent behavior.

Acknowledging feelings helps the client begin to look at what might happen if actions were acted on, own ability to control self and make choices regarding recovery.

Promotes awareness of feelings and ability to deal with them in acceptable ways.

Client's anger is directed at situation and those involved, not at healthcare provider, so remaining separate from the client allows therapist to be helpful to the resolution of the anger.

Provides parameters to help client deal with destructive thoughts/actions and helps to keep client safe.

Assist client to learn new coping skills (e.g., assertive rather than nonassertive/aggressive behavior, effective parenting techniques).

Promotes sense of self-worth and ability to control own actions/situation.

### **Collaborative**

Administer antidepressants as indicated.

Helps client deal with feelings of sadness and hopelessness and move forward in therapy. Age of client and nature of abusive situation affect depth of client's depression.

Refer to inpatient program as appropriate.

May require more intensive therapy to deal with covert forms of self-destructive behavior (e.g., substance abuse, heavy risk-taking/runaway behavior).

Refer to community resources (e.g., social services, AA, others), as appropriate.

Helps attain/maintain recovery program.

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### **NURSING DIAGNOSIS**

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### **FAMILY PROCESSES, altered [dysfunctional]/PARENTING, altered**

#### **May Be Related to:**

Situational crises (e.g., economic, illness, change in roles), developmental transitions [loss/gain of family member(s), blending of families]

Poor role model, lack of support systems; unrealistic expectation for self, infant, partner

Physical/psychosocial abuse of nurturing figure

#### **Possibly Evidenced by:**

Family system does not meet its members' physical, emotional, spiritual, or security needs

Inability of family members to relate to each other for mutual growth and maturation

Rigidity in functions, rules, roles; verbalization of inability to control child, resentment toward child, unresolved disappointment in gender or physical characteristics of child

Inattention to child needs, inappropriate caretaking behaviors, history of child abuse or abandonment, incidence of physical/psychological trauma

#### **Desired Outcomes/Evaluation Criteria—**

Express feelings freely and appropriately.

#### **Family/Parent Will:**

Demonstrate individual involvement in problem-solving process.

Engage in appropriate parenting behaviors.

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## **ACTIONS/INTERVENTIONS**

## **RATIONALE**

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### **Independent**

Determine composition of family, developmental stage, presence/involvement of extended family, use of special supports.  
recidivism.

Review type, severity, duration of problem, and contribution of, as well as impact on, individual family members.

Assess boundaries of family members such as whether members share family identity, have little sense of individuality, seem emotionally distant/not connected with one another.

Discuss parenting techniques and parents' expectations. Review developmental levels of children.

Note cultural and religious factors.

Discuss negative mode of individual interactions. Emphasize importance of continuous, open dialogue between family members using therapeutic communication skills.

Determine current "family rules." Identify areas of needed change.

Helps identify problem areas/strengths to formulate plans to change abusive situation. Lack of/ineffective use of support systems increases risk of

Affects choice of interventions. Abuse is an act of commission, whereas neglect is considered an act of omission. These behaviors indicate the presence of problems with relationships and/or parenting skills and individual problems such as inability to deal with stressors, substance abuse, mental illness, cognitive limitations, or criminality. Even if the behavior is the result of a single individual, all family members may be involved in the denial/coverup or even passive condoning of the behavior. Additionally, all family members will be affected by the disclosure of the behavior.

These factors are critical to understanding individual family dynamics and developing strategies for change. Family that pressures survivor to heal quickly/forgive offender, blames individual for causing pain by disclosing situation, fails to acknowledge significance of abuse, or minimizes/negates need for counseling is nonsupportive and will likely impede recovery process.

Ineffective parenting and unrealistic expectations contribute to abuse. Understanding normal responses, progression of developmental milestones may help parents cope with changes. (Refer to ND: Growth and Development, altered.)

Beliefs about family roles, parenting style, and religious beliefs may contribute to participation in/acceptance of practices that are seen as abusive.

Promotes successful interactions to break cycle of abuse. Keeping family secrets is destructive and can impede the change process.

Rules may be imposed by adults rather than through a democratic process involving all family members, leading to conflict and angry confrontations. Setting positive family rules with all family members participating can promote a functional family.

Identify and encourage use of previously successful coping behaviors.

Discuss therapeutic concept of forgiveness for covert acts as well as acts of omission.

Acknowledge realities of situation and inability to change others.

### **Collaborative**

Encourage family participation in multidisciplinary team conference/group therapy as appropriate.

Refer to classes (e.g., Parent Effectiveness), specific disease/disability support groups (including substance abuse resources)/spiritual advisor as indicated.

Refer family to community programs/resources (e.g., support/psychotherapy groups, social services as needed).

Everyone has positive ways of dealing with life stressors, and when these are identified and supported they can help to change abusive situation.

Forgiving others and oneself takes time, but can free individuals from the past, allowing them to move forward with life. Although forgiving does not condone the actions, it may help heal relationships.

Family may not change, or relationship may be permanently destroyed. Individual needs to go forward with own life and healing process.

Participation in family and group therapy for 13–18 months increases likelihood of success as interactional issues (e.g., marital conflict, scapegoating of the abused child) can be addressed/dealt with. Involvement with others can help family members to experience new ways of interacting and gain insight into their behavior, providing opportunity for change.

Can assist family to effect positive change/enhance conflict resolution. Parents may require positive role modeling to learn nonpunitive child-rearing techniques. Presence of substance abuse problems requires all family members to seek support/assistance in dealing with situation to promote a healthy outcome.

When the individual is willing to accept responsibility for past behavior, self-help organizations help families overcome stigma of situation and achieve greater self-esteem while providing professionally supervised treatment. **Note:** High dropout rates have been reported when abusive parents are referred to traditional community mental health clinics. Parents often view authority figures with suspicion and mistrust and require more personal approaches (e.g., 24-hour availability of counselors, evening and after-hours appointments).

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## **NURSING DIAGNOSIS**

### **May Be Related to:**

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## **GROWTH AND DEVELOPMENT, altered**

Inadequate caretaking (physical/emotional neglect or abuse)

Indifference, inconsistent responsiveness, multiple caretakers

Environmental and stimulation deficiencies

**Possibly Evidenced by:**

Delay or difficulty in performing skills (including self-care or self-control activities) appropriate for age

Altered physical growth

Loss of previously acquired skills, precocious or accelerated skill attainment

Flat affect, listlessness, decreased responses

**Desired Outcomes/Evaluations Criteria—**

Perform motor, social, and/or expressive skills

**Child Will:**

typical of age group, within scope of individual capabilities.

Perform self-care and self-control activities appropriate for age/development level.

**Parents/Caregivers Will:**

Verbalize understanding of developmental delay/deviation and plan(s) for intervention.

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**ACTIONS/INTERVENTIONS**

**RATIONALE**

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**Independent**

Determine existing condition(s) that contribute to developmental deviation. Note severity/pervasiveness of situation.

May be long-term physical/emotional abuse, situational disruption, or inadequate assistance during period of crisis or transition. Identifying individual situation of abuse/neglect guides choice of interventions.

Ascertain nature of parenting/caretaking activities and parents' expectations of the child (e.g., inadequate, inconsistent, unrealistic/insufficient expectations; lack of stimulation, inappropriate responsiveness and limit-setting).

Provides information about needs of family/child. Parents' unrealistic expectations of the abilities/independence needs of the child may lead to demands for behavior that the child is unable to accomplish or may interfere with the developmental process. **Note:** Conflict may especially arise during the preschool and teen years, when separation issues are paramount.

Identify developmental age/stage of child, expected skills/activities using authoritative texts (e.g., Gesell) or assessment tools (e.g., Draw-a-Person, Denver Developmental Screening Test).

Baseline information notes areas of deviation, skills affected, whether pervasive or one area of difficulty. Helps determine options/appropriate interventions.

Provide information regarding normal growth and developmental process and appropriate expectations for individual child.

Helps parents/caregivers to develop realistic expectations about child's abilities and potential.

Note significant stressful events that have occurred recently in the family.

Losses and separation such as the death of a parent, divorce, or unemployment may tax the supportive abilities of the parents/caregivers.

Avoid blame when discussing contributing factors.

Parents usually feel inadequate and blame themselves for being "a poor parent." **Note:** Adding blame will not be helpful for changing behavior.

Support attempts to maintain or return to optimal level of self-control or self-care activities.

Providing assistance enables parents to progress in learning new skills and helping child develop to fullest potential.

Involve parents/caregivers in role-play, group activities.

Provide list/copies of pertinent reference materials.

### **Collaborative**

Consult appropriate professional resources (e.g., occupational/rehabilitation/speech therapists, special education teacher, job counselor).

Encourage attendance at appropriate educational programs (e.g., Parent Effectiveness classes, infant stimulation sessions, nurturing programs).

Provides opportunities to practice new behaviors, enhance self-confidence and sense of self-worth.

Bibliotherapy provides information to encourage questions and additional learning.

A team approach is necessary to coordinate an individual plan of care to optimize child's growth and development.

Participation in these activities will provide parent with new skills to promote effective coping and enable avoidance of abusive/neglectful behaviors.

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### **NURSING DIAGNOSIS**

#### **May Be Related to:**

#### **Possibly Evidenced by:**

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

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### **SEXUAL dysfunction/SEXUALITY PATTERNS, altered**

Ineffectual or absent role models; impaired relationship with a significant other

Vulnerability

Physical/psychosocial abuse (e.g., harmful relationships)

Misinformation or lack of knowledge

Verbalization of a problem; reported difficulties, limitations, or changes in sexual behaviors or activities

Inability to achieve desired satisfaction

Conflicts involving values

Seeking of confirmation of desirability

Verbalize understanding of sexual anatomy/function.

Identify individual reasons/stressors contributing to situation.

Discuss satisfying/acceptable sexual practices.

Demonstrate improved communication and relationship skills.

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### **ACTIONS/INTERVENTIONS**

#### **Independent**

Discuss client's perceptions of sexuality as learned in family/relationships. Ask client about past abuse/sexual abuse during history taking.

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### **RATIONALE**

Gives permission to the client to talk about sex and in a safe environment. Many abused individuals feel guilty about sharing family secrets, fear reaction of others, and are concerned that they will not be believed.

Determine usual pattern of functioning and level of desire as well as vocabulary used by the client.

Identify sexual problems present for the client, e.g., using sex as a weapon to control/dominate partner; avoiding/afraid of sex; or engaging in promiscuous behavior, seeing sex as an obligation; fear, anger, or disgust with touching (particularly sexual touching); feeling emotionally distant during sexual activity; painful intercourse; or orgasmic difficulty.

Identify cultural, religious, and/or value factors and conflicts present.

Note substance use/abuse.

Avoid making value judgments and be aware of own feelings and response to client expressions, revelations, and/or concerns.

Provide information about anatomy /physiology and individual situation according to client needs.

Note coping style exhibited.

Encourage use of higher-level defenses (e.g., repression, sublimation, and intellectualization) by limit-setting, education, interpretation, and desensitization.

Set limits on seductive behavior when displayed. Help client distinguish the difference between acceptable and unacceptable behaviors.

Help client learn to say "No" to sex.

Encourage careful selection of future sexual partner and delaying sexual activity until a friendship is established. Suggest investigation of new partner's past involvement with the criminal system in regard to abusive behavior.

Provides information about how client views sexual activity and areas of lack of knowledge/ misinformation.

Sexual abuse is demonstrated in many different ways depending on the extent, duration, and presence of threat/fear of violence. Survivors and offenders require long-term therapy to change attitudes about sex, sense of self as a person/ sexual being, and general feelings related to the abuse.

Beliefs/values of client will affect view of what has happened and feelings about situation, influencing therapeutic treatment program.

May affect sexual function/satisfaction, requiring therapeutic intervention.

Judgments and negative responses do not help client to cope with situation and may result in client withdrawing and not talking further.

Lack of accurate knowledge may contribute to problems client is experiencing.

Client may use repetition and reenactment of the molestation/abuse incident(s) or may avoid sexual stimuli.

Successful intervention focuses on having the survivors become gradually aware of the painful memories and verbalize them instead of acting them out or avoiding them. **Note:** Goal of therapy is to free individual of emotional anesthesia and the sense of living a "lie," allowing client to begin to feel trust and tolerate intimacy.

The difference between acceptable physically affectionate behavior and behavior with sexual intent, as well as respect for own and others bodily privacy, needs to be learned. The sexually abused child may have difficulty differentiating affectionate from sexual relationships and may be aroused by routine physical or psychological closeness.

It is difficult for survivors to learn to say "Yes" to sex until they can learn to say "No" at any time.

Helps incest/abuse survivors develop a positive sexual experience. Individuals heal best in relationships high in emotional intimacy and support and low in expectations of sexual interaction. Past behavior/involvement with the justice system can provide clues to future problems that may be anticipated.

Encourage client to share thoughts/concerns with partner.

Identify sights, sounds, smells, and types of touch that are associated with the event/trigger flashbacks for the survivor. Discuss ways to minimize flashbacks/deal with triggers.

Tell the client that recovery is possible.

### **Collaborative**

Refer to clinical nurse specialist, professional sex therapist, family counseling as appropriate.

Appropriate self-disclosure in current/future relationships will help couple develop positive relationship.

Triggers can cause the feelings and fears to recur. Reexperiencing the event in a flashback is a traumatic occurrence and affects current relationship/intimacy.

Avoiding or learning to deal with triggers helps individual to remain in the safety of the present. For example, a specific sexual position may trigger anxious feelings/flashbacks. Sexual partner “allowing” survivor to take control, choose alternate position can lessen these feelings, promoting trust and enhancing emotional growth.

May believe that problems will last forever, and it can be reassuring to hear that therapy can help the client gain a positive, healthy perspective on sex and engage in positive relationships.

Problems may be deep-seated and require specialized/prolonged therapy.