Challenging Coworkers: Responding to Colleagues' Mental Health Issues

NYSNA Continuing Education

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How to Take This Course

Please take a look at the steps below; these will help you to progress through the course material, complete the course examination and receive your certificate of completion.

1. **REVIEW THE OBJECTIVES**

   The objectives provide an overview of the entire course and identify what information will be focused on. Objectives are stated in terms of what you, the learner, will know or be able to do upon successful completion of the course. They let you know what you should expect to learn by taking a particular course and can help focus your study.

2. **STUDY EACH SECTION IN ORDER**

   Keep your learning "programmed" by reviewing the materials in order. This will help you understand the sections that follow.

3. **COMPLETE THE COURSE EXAM**

   After studying the course, click on the "Course Exam" option located on the course navigation toolbar. Answer each question by clicking on the button corresponding to the correct answer. All questions must be answered before the test can be graded; there is only one correct answer per question. You may refer back to the course material by minimizing the course exam window.

4. **GRADE THE TEST**

   Next, click on "Submit Test." You will know immediately whether you passed or failed. If you do not successfully complete the exam on the first attempt, you may take the exam again. If you do not pass the exam on your second attempt, you will need to purchase the course again.

5. **FILL OUT THE EVALUATION FORM**

   Upon passing the course exam you will be prompted to complete a course evaluation. You will have access to the certificate of completion **after you complete the evaluation**. At this point, you should print the certificate and keep it for your records.

Course Objectives

Upon completion of this course, the learner will be able to:

- Discuss the prevalence of mental illness in today's society.
- Identify common psychiatric disorders.
- Describe Roach's five "C's of nursing.
- Identify assessment data that can be helpful in identifying psychiatric illness in colleagues.
- Discuss interventions that can be helpful regarding colleagues' psychiatric illness.

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Introduction

How often have you worked with someone who is "difficult", "intense", "emotional", or "not quite right"? Do you have colleagues who keep to themselves, who are angry all the time, who are very preoccupied, who may be absent frequently? Do you work with others who you consider "weird" or "strange"? Have you been concerned about a colleague or a coworker whose behavior has changed recently? How often have you or others merely given this individual a label and then tried to avoid him or her? Just as many of your colleagues and coworkers have heart disease, hypertension, cancer or diabetes, they may very well also have a psychiatric disorder.

Nursing is often identified as a holistic practice. As nurses, we consider the patient from a biopsychosocial perspective. However, in reality we often compartmentalize the physical and the psychiatric. From a holistic perspective, both the physical and psychiatric aspects contribute to the entire being. Do we really look at all aspects?

In the workplace nurses would likely identify and possibly intervene, if a colleague showed signs of a physical illness such as hypoglycemic reaction. So might we need to identify and possibly intervene in a coworker's psychiatric illness. Just as we might consider a diabetic coworker's dietary needs when planning a work-based celebration, we might also consider a depressed coworker's fatigue and difficulty concentrating as a health problem that could contribute to the decreased quality of their work.

As a society, we have long held biases against those with mental illness. Mental illness was thought to have been the retaliation of angry or insulted Gods. Later in our collective history, "evil spirits" were driven out of the afflicted individual through prayer, drilling holes into the head to allow "the spirits" to escape. Persons with mental illness were subjected to a variety of clearly questionable "treatments", including flogging, drowning, being chained, being subjected to insulin shock, cold packs, etc. We did not understand the nature of mental illness; even today, despite much progress, there is still much to be learned about mental illness. Despite our current biopsychosocial perspective of the etiology of mental illness, one thing that has persisted: those with mental illness continue to be stigmatized.

Persons with psychiatric disorders work in a multitude of occupations—including healthcare. Identifying and understanding symptoms, and providing helpful interventions, or at the very least, reframing the meaning of behavior, can help to make the work environment a more healthy and productive place for all. ***It is important, however to remember that our colleagues and coworkers are not our patients. We will not provide treatment or care for them. We must honor the boundaries of our working relationships.***

Let's look at a few examples:

- Judy W., an ICU nurse for 20 years, is the nurse manager on a unit in which the nurses have generally worked well together as a team. However, for the last 2 months the nurses, as well as the physicians and respiratory technicians have had a number of conflicts; several staff have requested transfers to other shifts or units and one nurse is threatening to quit entirely. Judy has been trying to problem solve the situation, however, she believes it comes down to personality issues among the staff. Looking back, she recognizes that the problems began about 3 months ago when Maura transferred from the emergency department to the ICU. Maura is younger than most of the other nurses and is quite excitable and has had several shouting matches with coworkers. She also has an exciting social life, which she has often talked about in great detail. In fact, since she came to work on the unit, she has had 2 boyfriends, one of whom she had moved in with after just a week of knowing him. That was 2 weeks ago. Today, she called in sick after taking 20 aspirin -- she was so distressed because this new boyfriend now wants her to move out! This is the 5th day she has taken off since working on the unit, due to emotional distress. The other nurses have been complaining that she is so preoccupied with her chaotic life that she is not a productive member of the team, others frequently having to follow up on her work. Judy now realizes that several physicians and respiratory therapists have complained to her about Maura and her frequent outbursts of anger and tearfulness. Judy has generally only

seen Maura behaving in a relatively professional manner, but recalls a situation in which a patient's family member approached her to request a day off for Maura because she was so overworked and had so many personal problems.

- Jan has a reputation among her coworkers as being "weird". Some days she is fairly productive and attentive to her work, and other days she seems to focus on just one or two patients or activities, neglecting the larger work unit. Jan tends to dress in an erratic style, often layering on multiple items of clothing; her hair often looks unclean. Jan is frequently preoccupied and anxious, and several staff members have begun to complain that Jan is mumbling or giggling to herself a lot. She is frequently irritable and often not at all easy to get along with. Several of the nursing assistants have complained to the nurse manager that they do not want to work with her because she is so difficult. The nurse manager recalled that a few years ago, Jan also went through a period where she was irritable and anxious and complained that her coworkers were talking about her and plotting to take her job. She took a sudden medical leave right after having an incident with a physician in which she accused him of reporting her to the Board for Nursing. After she returned to work from the medical leave, two months later, she was less moody and more able to get her work done.

- Sam is an evening supervisor of a long term care facility in which he has worked for 12 years. Other employees are noticing that over the past year, Sam is often irritable and short-tempered. His frustration tolerance has decreased; he now struggles with situations that he used to handle with good natured skill. He used to volunteer for social activities at the facility, often chairing the committee on employee morale. He has quit the committee and no longer volunteers for staff activities. He has also stopped meeting some of the other nurses for coffee during breaks. Sam's wife of 30 years died in a car accident about 2 years ago. He was sad and quite distressed after her death, but with the help of his grown children, other family members and his friends he seemed ok. But for the past year, Sam has become increasingly irritable and isolated.

- Laura is a relief nurse on a surgical unit on the evening shift. She is often called in to work when Mark, another RN, is off. Laura has been replacing Mark approximately once or twice per week, apart from his scheduled days off. Mark usually volunteers to pass medications, so when Laura works, she is usually assigned this task. Laura is confused by the patients' comments that they like it when she works because the medication always works well when she gives it. During her break, Laura chats with one of the other nurses, who mentions that Mark is out sick often and even when he does come to work, he is generally passing meds, or is in the bathroom or on break. She confides that she thinks something is going on with Mark.

Would you recognize the above symptoms of a psychiatric disorder in your colleagues? What you learned in your nursing education about psychiatric nursing was related to the patients in your care. However, mental illness is everywhere. It can affect you, your family, your friends, and your coworkers. Recognizing symptoms and accessing assistance for ourselves and/or our colleagues can help to make the work environment significantly less distressing and more productive and collegial. This course will help you to apply basic psychiatric nursing information to the non-psychiatric clinical setting, where our colleagues as well as our patients can be assisted.

The Scope of Psychiatric Disorders

Psychiatric disorders are common in the United States as well as internationally. An estimated 22.1 percent of Americans ages 18 and older—about 1 in 5 adults—suffer from a diagnosable mental disorder in a given year (NIMH, 2004). When applied to the 1998 U.S. Census residential population estimate, this figure translates to 44.3 million people. In addition, 4 of the 10 leading causes of disability in the U.S. and other developed countries are mental disorders: major depression, bipolar disorder, schizophrenia, and obsessive-compulsive disorder. Many people suffer from more than one mental disorder at a given time. The people affected by mental illness are not just our patients, but our colleagues, co-workers, our supervisors, our friends and relatives, even ourselves.

In *Global Burden of Disease* (1990), The World Health Organization, Harvard University and The World Bank studied the burden of mental illness on health. The study developed a single measure to allow comparison of the burden of disease across many different disease conditions by including both death and disability. This measure was called Disability Adjusted Life Years (DALYs). DALYs measure lost years of healthy life regardless of whether the years were lost to premature death or disability. The disability component of this measure is weighted for severity of the disability. For example, disability caused by major depression was found to be equivalent to blindness or paraplegia whereas active psychosis seen in schizophrenia produces disability equal to quadriplegia.

Using the DALYs measure, major depression ranked second only to ischaemic heart disease in magnitude of disease burden in established market economies. For women throughout the world as well as those in established market economies, depression is the leading cause of DALYs.

Ten leading causes of DALYs in developed regions, 1990 (WHO, 1990)

	DALYs (thousands)	Percent of total
All causes	160,944	
1. Ischaemic heart disease	15,950	9.9
2. Unipolar major depression	9,780	6.1
3. Cerebrovascular disease	9,425	5.9
4. Road traffic accidents	7,064	4.4
5. Alcohol use	6,446	4.0
6. Osteoarthritis	4,681	2.9
7. Trachea, bronchus and lung cancers	4,587	2.9
8. Dementia and other degenerative and hereditary CNS disorders	3,816	2.4
9. Self-inflicted injuries	3,768	2.3
10. Congenital abnormalities	3,480	2.3

Categories of Psychiatric Disorders

There are many different psychiatric disorders. *The Diagnostic and Statistical Manual of Psychiatric Disorder IV-Text Revised* (DSM IV-TR) (APA, 2000) lists each currently accepted psychiatric diagnosis, including the criteria needed in order to make each diagnosis. While this course will not provide in-depth information about each and every diagnosis, broad categories of psychiatric illness will be addressed. These include: mood disorders, anxiety disorders, psychotic disorders, personality disorders and substance use disorders. There are many specific disorders under each of these broad categories, as well as additional broad categories; the reader is directed to the DSM-IVTR for more detailed information.

Mood Disorders

Mood disorders are generally defined as depressive disorders which include Major Depressive Disorder, Bipolar Disorder, Dysthymia, Cyclothymic Disorder, Postpartum Depression and Seasonal Affective Disorder, among others. According to the National Institute of Mental Health (NIMH, 2001):

- Approximately 18.8 million American adults, or about 9.5 percent of the U.S. population age 18 and older in a given year, have a depressive disorder.
- Nearly twice as many women (12.0 percent) as men (6.6 percent) are affected by a depressive disorder each year. These figures translate to 12.4 million women and 6.4 million men in the U.S.
- Depressive disorders may be appearing earlier in life in people born in recent decades compared to the past.
- Depressive disorders often co-occur with anxiety disorders and substance abuse.

Depressive symptoms include: depressed mood, loss of interest in usual activities, fatigue, change in appetite and sleep patterns, feelings of hopelessness and thoughts of death or suicide. Frequently, irritability, and low frustration tolerance are also present.

As above, thoughts of death or suicide are symptoms of depression. According to NIMH (2002):

- In 1997, 30,535 people died from suicide in the U.S.
- More than 90 percent of people who kill themselves have a diagnosable mental disorder, commonly a depressive disorder or a substance abuse disorder.
- The highest suicide rates in the U.S. are found in white men over age 85.
- The suicide rate in young people increased dramatically over the last few decades. In 1997, suicide was the 3rd leading cause of death among 15 to 24 year olds.
- Men's suicide rate is four times that of women; however, women attempt suicide 2-3 times more than men.

Anxiety Disorders

Anxiety disorders, as the name suggests, are those in which the predominant symptom is anxiety. It can manifest in multiple ways; multiple specific anxiety disorders exist. Among them are:

- **Acute Stress Disorder –** In response to an identified stressor, people experience high levels of anxiety, poor sleep patterns, increased vigilance, nightmares, flashbacks. This occurs immediately after a traumatic event and can last up to 2 months.

- **Post-Traumatic Stress Disorder (PTSD) –** This disorder begins at least 4 weeks after a traumatic event, and may not manifest until years later. High anxiety, labile mood, flashbacks, nightmares, and sleep disturbance are all symptoms of PTSD.

- **Panic Disorder –** Persons with panic disorder have episodes of such extreme anxiety and/or fear that, at least initially, they believe they are having a heart attack. The panic descends quickly and

generally last up to 2 hours. This is a debilitating illness; people often begin to avoid the places or circumstances in which the panic attack occurred, for fear of having another attack. This then creates even further limitations in the person's life**.**

- **Generalized Anxiety Disorder –** This disorder is characterized by excessive anxiety and worry about a variety of events or activities in the person's life. It may be accompanied by some or all of the following: restlessness or feeling on edge; being easily fatigued; difficulty concentrating; irritability; muscle tension; sleep disturbance.

- **Obsessive-Compulsive Disorder –** Persons with this disorder have recurrent and persistent thoughts, impulses or images (obsessions) that are disturbing and intrusive and cause anxiety. These obsessions are accompanied by compulsions or repetitive behaviors or mental acts (counting, word repetition, etc.) that the person utilizes in response to the obsession, or in response to their own rigidly held rules. The behaviors are a means of managing the obsessions.

According to NIMH (2001):

- Approximately 19.1 million American adults ages 18 to 54, or about 13.3 percent of people in this age group in a given year, have an anxiety disorder.
- Anxiety disorders frequently co-occur with depressive disorders, eating disorders, or substance abuse. Many people have more than one anxiety disorder.
- Women are more likely than men to have an anxiety disorder. Approximately twice as many women as men suffer from panic disorder, post-traumatic stress disorder, generalized anxiety disorder, agoraphobia, and specific phobia, though about equal numbers of women and men have obsessive-compulsive disorder and social phobia.

Psychotic Disorders

Psychotic disorders are all the psychiatric disorders in which one exhibits psychotic symptoms. Psychotic symptoms are symptoms that are not based in reality. Delusions and hallucinations are psychotic symptoms.

Delusions are beliefs that are not based in reality, for example the belief that one is being targeted by the government for persecution is considered a **paranoid or persecutory delusion.** Belief that one has special powers, for example that one holds the key to world peace, is a **delusion of grandeur.**

Hallucinations are sensory experiences that are not based in reality, for example hearing voices is an **auditory hallucination,** seeing things or people that are not real is a **visual hallucination.** Hallucinations can also be tactile, olfactory and gustatory (touch, smell and taste).

The most common psychotic disorder is **schizophrenia.** Schizophrenia is a severe mental illness, the symptoms of which can be immensely devastating to almost all aspects of a person's life. It consists of positive symptoms (such as delusions and hallucinations) and negative symptoms (such as blunted affect and social withdrawal). Schizophrenia is a chronic illness, which must be managed well in order to minimize or eliminate symptoms. Persons with schizophrenia may have long periods of stability and episodic exacerbations of symptoms in a lifetime. Others with schizophrenia may not achieve much symptoms relief, and are constantly in one acute episode after another.

NIMH (2001) reports that:

- Approximately 2.2 million American adults, or about 1.1 percent of the population age 18 and older in a given year, have schizophrenia.
- Schizophrenia affects men and women with equal frequency.
- Schizophrenia often first appears earlier in men, usually in their late teens or early 20s, than in women, who are generally affected in their 20s or early 30s.

Another psychotic disorder is **Schizoaffective Disorder**, in which the symptoms of both schizophrenia and an affective disorder or depression are present.

Personality Disorders and Personality Traits

Personality disorders are more difficult to identify. The personality is one's characteristic way of being and interacting with the world. Some people are "easygoing"; others are "high strung". Much has been made of the so-called "Type A" personality who is considered to be driven and hard working. These characteristics are constant in the individual, generally consistent in most aspects of life. For example, the person with "Type A" personality will exhibit their "driven" quality at work, by having the highest percentage of repeat clients in her or his organization. This same person enjoys playing tennis and is competitive at the game and enjoys winning. At home, this person likely is very organized, keeping a clean and tidy home. Personally, this person is fastidious about her or his own personal hygiene, always looking well put together.

Many of us can identify our own, as well as others' personality traits.

In some people, the personality itself is disordered, so that the individual's characteristic way of being and interacting with the world is the disorder. Persons with **antisocial personality disorder**, for example, tend to be self-centered and self-serving and yet can be quite charming. They tend to not care about society's rules, believing that the rules, or even laws, do not apply to them. They do not consider the impact of their behavior on others. A person with antisocial personality disorder will approach the world from this perspective at all times, in all aspects of their lives—in interpersonal and intimate relationships, at work, at school, at home, etc. This perspective is a constant part of who they are.

Other personality disorders include:

- **Borderline Personality Disorder** – Persons with this disorder tend to have very chaotic, intense relationships. They have difficulty managing their feelings, often having intense fluctuations in their moods (mood lability). Many with this disorder have self-destructive behaviors, such as cutting or burning themselves; they may make frequent suicide attempts. Persons with this disorder have unstable self-image and chronic feelings of emptiness.

- **Dependent Personality Disorder –** Persons with this disorder are very dependent. They seem to be unable to function without the help of others, including an inability to make everyday decisions. They lack self-confidence and feel helpless.

- **Schizoid Personality Disorder –** Persons with this disorder are frequently loners, having few social contacts. They may be emotionally distant and exhibit flatness to their affect.

- **Histrionic Personality Disorder** – Persons with this disorder exhibit a pervasive pattern of excessive, unstable emotionality; they have a very difficult time being alone so are, therefore, attention seeking. Also present may be discomfort at not being the center of attention; sexually seductive or provocative interactions with others; shallow and rapidly shifting expressions of emotions, easily suggestible; inappropriate familiarity, i.e., considers relationships to be more intimate than they actually are; dramatic, theatrical style which draws attention to oneself.

Substance-Related Disorders

Possible substances include: Alcohol, amphetamines, caffeine, cannabis, cocaine, hallucinogens, inhalants, nicotine, opioids, phencyclidine, sedatives, hypnotics, anxiolytics and polysubstance, meaning a combination of multiple substances.

- **Substance Dependence –** Impairment or distress associated with tolerance of the substance, that is a need for increased amounts of the substance to achieve intoxication or the desired effect; and withdrawal symptoms when the substance is not utilized..

- **Substance Abuse** – Recurrent substance use that leads to failure to fulfill major role obligations at work, school and home; relationships suffer; legal problems may arise.
- **Polysubstance abuse and dependence** – Abuse and dependence on multiple substances

Nursing – A Caring Profession in Context

Caring is at the core of the practice of the profession of nursing. Multiple nursing theorists have included caring as a component of their approach to nursing. Roach (1987) identified the five "C's" of caring: compassion, conscience, competence, confidence, and, commitment. No one would argue that caring for patients is central to the practice of nursing.

However, nursing, as a profession, has been accused of "eating it's young". Some believe that nurses, while being caring to patients and families, have limited ability to extend that care to one another, including new and inexperienced nurses, or nurses who are "different".

Perhaps we hold each other to the same high standards we require of ourselves, thereby not always being as understanding as we could be with our colleagues. Perhaps we are victims of our culture, and we maintain those cultural prejudices and biases against those with mental illness. Perhaps we have not quite accepted that nursing is a holistic profession, one that cares for the entire, or whole, person, including the mind and body. Some separate the mind and body and cannot see that in a holistic discipline, they are both interrelated aspects of one being.

Weiner, Perry & Magnuson (1988), in their classic research, studied responses to persons with mental disability and those with physical disability. They found that people in general believe that those with physical disability are not responsible for their illness and that they are worthy of assistance. In contrast, they found that people in general, believe that those with psychiatric disability are responsible for their illness and are not worthy of assistance. Perhaps, like the subjects in the study above, some nurses may believe that those with mental illness do not have a legitimate illness and are responsible for their illness. Perhaps we think that those with mental illness should just "try harder", or "snap out of it" and "will" the illness away.

Would we ask the same of those with physical illness? Do you think that those with hyperlipidemia just need to try harder to "will" their triglyceride levels down? How about those who have suffered a cerebral vascular accident, do we merely say to them "snap out of it"? Do you think that those with serotonin, dopamine and epinephrine imbalances—such as might be found in many mental illnesses-should "try harder" to make their neurotransmitters come into balance?

So, applying the 5 "Cs" of caring (compassion, conscience, competence, confidence, and commitment) to our colleagues would be beneficial to our colleagues, ourselves, our workplace, our patients and to society as a whole. Being **compassionate** towards colleagues means having awareness that something is not right and having the willingness and ability to look beyond a label, for example, "She's a nut-job."; "Joe's a weirdo."; "Don't even try to help her, she's crazy."; "What can I do with someone who's that nuts?". Applying compassion to our coworkers begins after we drop the labels.

Beginning to understand that there is meaning in the behavior is **conscience** at work; it is not enough to label, nurses can be motivated by the core principle of caring to be helpful to colleagues. Additionally, even if, as a nurse, you do not extend caring to your colleagues, your conscience relative to possible adverse outcomes in patients, secondary to the psychiatric illness of colleagues, can serve as a motivator.

As nurses, we need **competence** and **confidence** to manage the illness of colleagues. Perhaps we don't intervene because we don't know what to do. Competence includes not just physical assessment, which most nurses are able to do very well, but mental status and behavioral assessment as well. Nurses need knowledge and skill in assessment of mental status, mood, behavior and cognition. We need to develop competence in a range of healthcare activities and have the confidence to utilize our assessment

skills. We then must **commit** to facilitating the care that is needed in order to help our colleagues. In a later section of this course, suggestions for intervention will be provided.

A Word About Boundaries

Boundaries. Just what is meant by that word? Boundaries are not a method for keeping others at a distance…they are not a limit to friendship or a coworker relationship… nor just an abstract concept coined by Freudian analysts with no real connection to our current lives... Boundaries are the parameters of a relationship. What lies within the boundaries are acceptable ways of interacting, of communicating, space, distance, tone of voice, touch, the content of communications, the words we use, etc. What lies outside the boundaries are not acceptable within the context of that relationship.

Boundaries are relative. One has different boundaries for the various relationships in which one engages. What you talk about with your intimate partner is different from what you talk about with your patients. The physical distance between you and your family members is different from the distance between you and your coworkers. We behave, think and feel in a different context based on the various relationships we have.

Boundaries are permeable; for that reason their limits must be assured. It is no more appropriate for a coworker to be involved in the intimate details of one's sexual relationship with one's life partner than it is for a parent to shake hands with one's 3 year old child when picking them up from day care. In the context of professional relationships, we must maintain good working relationships that allow for enough closeness and collegiality with our coworkers without infringing on personal matters. Our colleagues need our friendliness and willingness to share interests and expertise relative to our work, they do not need a therapist or counselor or mother or best friend. Our colleagues need for us to maintain good boundaries and respect the limits of the relationship, but also not to keep the distance arbitrarily too far.

The Nursing Process Applied

The nursing process includes assessment, diagnosis, planning, intervention and evaluation. The nursing process is called, by disciplines other than nursing, the scientific method. It provides an organized, methodical process for solving problems. Nurses are very knowledgeable about the application of the nursing process to patient care, however, it can also provide a framework for the management of problematic situations with colleagues.

The first step in the process is assessment. Assessment includes all the data that can be obtained that may be relevant. Nurses are skilled at physical assessment of patients: skin color, vital signs, lung sounds, cardiac status, etc. Some nurses also have skill in assessing mood and behavior, often referred to as mental status assessment. It is important to remember that assessment must always occur in context.

Perhaps the most important question to ask is: what is different about this nurse? How long has this been going on? What is the person's mood (the pervasive emotional state)? Has there been any significant change in mood recently? Is the mood generally consistent, or is there rapid fluctuation in mood? Does his or her non-verbal behavior match the mood? Are there discrepancies between what is said and what is done? What is the speech like? Is it pressured, rapid? Is it slow and deliberate? Are the thoughts logical, organized and reality based? Are comments self-effacing? Or are they self-aggrandizing? What is the anxiety level like? What about energy level? Is the energy goal directed, or are they running around getting little done? Is the person easily distracted or are they able to get tasks completed? Is the person experiencing distortions in her or his sensory experiences? Is she or he experiencing auditory or visual hallucinations? Are there distortions in the other senses? Has this person been experiencing any new, unusual beliefs? Has this person's beliefs become more skewed and distorted?

Has there been any change in the person's behavior? Is this someone who has always been very organized and productive but now slowed, or are they very busy but unable to actually accomplish tasks? Is the coworker who has always been cooperative and easy to get along with now irritable and angry all the time, or quiet and withdrawn?

When did these mood and behavior changes occur? Was it sudden? Did it occur gradually? Were there precipitating factors? What impact does the individual's change in mood and behavior have on others?

Let's look at the case studies listed above. What assessment data is available about Maura and her work unit? Maura is relatively new to the ICU. Since she began working there, only 3 months ago, relationships among staff have suffered. Maura has a history of intense, chaotic relationships, one week after moving in with her latest boyfriend, he asks her to move out. She exhibits lability of her mood, fluctuating between multiple intense emotions. She has boundary problems in that she shares personal information about herself, and her own personal problems, with her patients and their families. She is impulsive, moving in with this boyfriend after knowing him for only 1 week, as well as the suicide gesture today of taking 20 aspirin tablets. What do you think might be going on with Maura?

Although, as previously stated, as nurses we will not diagnose and treat our coworkers, however understanding what may be occurring with our colleagues can be quite useful. For Judy, the nurse manager of the unit where Maura works, it is important to identify the problem correctly and intervene appropriately. If Judy identified the problem as short-staffing, she would not necessarily intervene effectively. Would you be surprised to know that Maura has borderline personality disorder?

Jan has schizophrenia. She is generally well controlled on medications, but periodically has exacerbations. Like many chronic illnesses, although generally stable, episodes of acute symptoms occur in schizophrenia. When her symptoms begin to recur, Jan has auditory hallucinations and also has paranoid delusions. Her hygiene suffers and she looks unkempt. Being so frequently distracted and preoccupied by her auditory hallucinations, her anxiety level increases and her concentration and focus

suffer dramatically. Jan has had multiple hospitalizations in order to restabilize her on medications. Did you know that Jan has schizophrenia?

Sam is depressed. He had previously been an active, social person, until the sudden death of his wife. He grieved for her and seemed to be doing well, but has begun to have significant depressive symptoms over the past year. His mood is depressed and irritable, he has a decreased energy level and has lost weight. He is isolative and no longer enjoys activities that used to give him pleasure.

Mark has a substance abuse problem. He is addicted to Demerol and has been diverting patient medications for his own use. Patients have commented that the medication he provides them is ineffective—he has likely been injecting them with saline. Mark has also had frequent absences, which arouses the suspicion that Mark may have multiple issues, possibly related to his drug addiction.

Now that you have assessed your coworkers and identified potential health problems, now what? Let's consider the nursing process. The next step after assessment and diagnosis is planning. What can you do to help in these situations? Much depends on your relationship with the coworker. Are you friends? Do you merely have a working relationship and never discuss anything of a personal nature? Regardless of your relationship, it is reasonable to say to the coworker, "I'm concerned about you; I've noticed some changes in you lately."

What are the resources available to you in your place of work? Do you have a supervisor? An Employee Assistance Program (EAP)? Are there psychiatric clinical nurse specialists or psychiatric nurse practitioners available for consultation?

One of the first interventions should be to contact your supervisor. Share your observations and concerns. Are you worried about the coworker? Are you worried about the coworker's ability to care for patients safely? Are you worried about the impact this coworker is having on the work environment and working relationships? What **specifically** is the problem? What changes have you noticed? It is not enough to believe that a coworker is behaving "differently" or "weird" or "odd". It is necessary to identify your assessment data to your supervisor. Often the supervisor will have additional information about the coworker, and your observations can help to set in motion, the interventions needed to address the problem.

What about your organization's EAP? The goal of an EAP is to restore employees to full productivity. More specifically, the EAP provides free, confidential short term counseling to identify the employee's problem and, when appropriate, make a referral to an outside organization, facility, or program that can assist the employee in resolving his or her problem. It is the employee's responsibility to follow through with this referral, and it is also the employee's responsibility to make the necessary financial arrangements for this treatment, as with any other medical condition.

EAPs are available for employees who have alcohol and/or drug problems who are seeking rehabilitation and the opportunity to become fully productive members of the workforce. Managers and supervisors are urged to become familiar with the EAP and to make referrals and/or recommend to employees that they seek help through the EAP. Participation in the EAP is voluntary and, ultimately, it is the employee's decision to participate or not.

In addition to substance abuse problems, most agency EAPs provide comprehensive counseling and referral services to help employees achieve a balance between their work and family and other personal responsibilities. Job effectiveness can be adversely affected when employees are faced with mental or emotional problems, family responsibilities, financial or legal difficulties, or dependent care needs. The EAP can be extremely important in the prevention of, and intervention in, workplace violence incidents; the delivery of critical incident stress debriefings; and providing assistance to employees during agency restructuring.

Besides EAP, contacting the New York State Nurses Association (NYSNA) Statewide Peer Assistance Program (SPAN) specifically for nurses with substance abuse problems in the state of New York may be helpful. SPAN is a program for registered nurses in New York State. The program helps to support the return of nurses affected by addictive illness to safe, effective practice by providing nurse-specific support groups, ongoing advocate support and linkages with resources. Stigma, licensure issues, guilt over the possibility of not having provided one's best effort to patients combine with factors experienced by many addiction clients to create special needs for nurses. SPAN can provide useful information and support to nurses as they seek treatment, support and management of their licensure status and assist with re-entry into the practice setting.

Consult with the psychiatric clinical nurse specialist or psychiatric nurse practitioner in your agency. Often advanced practice psychiatric nurses are available to provide information and interventions that can help in the situation. Many organizations utilize advance practice psychiatric nurses for consultation to nursing staff regarding patient issues. Inevitably, staff issues are also addressed. Do you have an employee assistance program available at your workplace? Talking with someone about your thoughts and feelings can help to start the process of help for the coworker.

Now that you have developed a plan based on some of the suggestions above, implementation is the next step in the nursing process. Implementation, in this situation, generally is not undertaken by coworkers; supervisors and mental health professionals should provide the actual interventions that facilitate treatment. However, coworkers need some information about the individual. Often, having the information that the identified coworker is on a medical leave is enough. For the worker's own confidentiality, details are generally withheld.

However, if the entire work unit has been impacted by the coworker's illness, some intervention with the staff will also be needed. Coworkers may feel angry and/or fearful, or have a variety of other responses, particularly if the problem has been allowed to persist for a long period of time, or if the individual coworker's mental health issues impacted greatly on coworkers or patients, particularly if it contributed to an adverse patient outcome. EAP intervention for the entire work unit, as a group, might also be in order. A debriefing with a qualified professional may help coworkers deal with their own feelings as well as gain understanding of their colleague's situation.

Intervention may be needed prior to the coworker's return to work. A debriefing for the staff may be in order in order for others to be informed of any practice restrictions on the part of the returning nurse, and understanding and problem solving how those restrictions will impact on them. Co-workers should seek assistance from management or EAP if they continue to struggle with how to respond to the returning nurse.

Once the interventions have been enacted, evaluation is needed. What are the results? Has your coworker been assisted to resolve their problems or illness? Has the workplace become more functional and harmonious? Have you, as a nurse, grown in your ability to identify and intervene productively in a colleague's psychiatric disorder?

Conclusion

Just like members of the general public, individuals in the nursing profession have a variety of health problems, including mental illness. These nurses with mental health issues work in a range of settings; they are our friends, our colleagues, ourselves. It is important to be knowledgeable and sensitive. By recognizing and intervening you help your colleague, yourself, and your coworkers as well as the patients in your care.

Perhaps, as members of a society that stigmatizes those with mental illness, nurses' struggles with the mental illness of colleagues is to be expected. However, this does run contrary to nursing's long tradition of caring. As a profession we must learn to rise above feelings of prejudice, fearfulness and lack of knowledge of how to intervene. As a profession, we need to extend that caring to our colleagues who may be dealing with mental illness - in the same way that we care for coworkers with physical illnesses.

References

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition, Text Revision. Washington, DC: American Psychiatric Association.

National Institute of Mental Health (NIMH) 2004. *Statistics.* Accessed July 2004 at http://www.nimh.nih.gov/healthinformation/statisticsmenu.cfm.

National Institute of Mental Health (NIMH) (2001). *The Numbers Count: Mental Disorders in America.* July, 2001. Accessed March, 2002 at http://www.nimh.nih.gov/publicat/numbers.cfm

Roach, S. (1987). *The human act of caring*. Ottawa: Canadian Hospital Association.

Weiner, B., Perry, R. P., & Magnusson, J. (1988). An attributional analysis of reactions to stigmas. *Journal of Personality and Social Psychology*, 55(5), 738-748.

World Health Organization, Harvard University and The World Bank. *The Global Burden of Disease.* Accessed March 2002 at http://www.who.int/msa/mnh/ems/dalys/intro.htm

Challenging Coworkers: Responding to Colleagues' Mental Health Issues
Course Exam

After studying the downloaded course and completing the course exam, you need to enter your answers online. **Answers cannot be graded from this downloadable version of the course.** To enter your answers online, go to e-leaRN's Web site, www.elearnonline.net and click on the Login/My Account button. As a returning student, login using the username and password you created, click on the "Go to Course" link, and proceed to the course exam.

1. Approximately 1 in 5 adults in the United States suffer from a mental illness.

    A. True.
    B. False.

2. The World Health Organization's *Global Burden of Disease* identified a measure of the lost years of healthy life due to death and disability and then weighted the measure for severity of the disability. Worldwide, they discovered that depression ranked

    A. First.
    B. Second.
    C. Twenty-fifth.
    D. Last.

3. In *Global Burden of Disease,* Schizophrenia was ranked in severity with quadriplegia.

    A. True.
    B. False.

4. Symptoms of depression include

    1. Isolation
    2. Depressed mood
    3. Thoughts of death or suicide
    4. Disturbance in sleep and appetite

    A. 1, 2 and 3
    B. 2 and 3
    C. 2 only
    D. All of the above.

5. Personality Disorders are often difficult to identify because it is the individual's characteristic way of being, or personality, that is problematic.

    A. True.
    B. False.

6. Anxiety and substance abuse disorders are often co-morbid conditions of depression.

    A. True.
    B. False.

7. Roach's 5 "C's" of caring (compassion, conscience, competence, confidence, commitment) are examples of caring that can only be applied to patient care, not to psychiatric illness in colleagues.

    A. True.
    B. False.

8. When a mental health problem is suspected in a colleague, the best thing for a nurse to do is

    A. Label the individual as "nuts" and avoid them at all costs.
    B. Take it upon yourself to counsel them and help them through their problems.
    C. Share your concerns with the individual and seek assistance from supervisors or the Employee Assistance Program.
    D. Understand that the person has problems and make excuses for their symptoms and behaviors, and take on additional work assignments so that they will not be responsible for a difficult work load.

9. Employee Assistance Programs (EAP) are available to employees for assessment, short-term counseling and referral, if needed. The goal is return the individual to productive employment.

    A. True.
    B. False.

10. At times it may be necessary for staff who work with the individual who has a mental health problem to receive debriefing from a qualified mental health professional.

    A. True.
    B. False.