Doctorate Program

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026801

Evidence-based practice in psychiatric and mental health nursing

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Objectives

At the end of this discussion each candidate will be able to:

- Explain concept evidence-based practice (EBP)
- Determine how EBP concept has been developed
- Identify the component of EBP.
- Discuss the benefits of (EBP)
- Explain how evidence be incorporated in nursing practice

Objectives

At the end of this discussion each candidate will be able to:

- Differentiate between Evidence –based nursing versus nursing research utilization
- Discuss the challenges of EBP.
- Explain Evidence-Based Treatment Practices in Mental Health Nursing

Outlines:

- History of the EBP movement
- Definitions of evidence based, EBP and evidenced based psychiatric nursing.
- Components of evidence based nursing practice
- Purpose of EBP in psychiatric nursing.
- Evidence –based nursing versus nursing research utilization

- Barriers to Evidence-Based Practice Utilization in Psychiatric/Mental Health nursing.
- Strategies to promote evidence-based practice / evidence-informed decision- making by psychiatric nurses.

Introduction

Health care organizations are beginning to create mechanisms to facilitate the process of information translation from the literature to practice.

Health-care providers by their nature have always been interested in the **outcomes** or **results of a patient's care.**

Traditionally, the focus has been on morbidity and mortality

Introduction

Today, the focus has broadened to include **clinical** *(e.g.*, symptoms); ***functional*** *(e.g., performance of daily activities);* ***quality of life*** *(e.g.* patient satisfaction); and ***economic*** *(e.g., direct costs, indirect costs, intangible* costs) outcomes.

Introduction

Psychiatric and mental health nursing practice continues to be strongly influenced by tradition, unsystematic trial and error, and authority.

Yet the need for quality care that is based on the best and most current empirical research is well documented.

Cont.

Achieving evidence-based practice in the psychiatric nursing specialty will require that qualified nurse researchers conduct research relevant for practice and appropriately disseminate that research to those who can best use it, practicing nurses.

Evidence-based practice

- **There are many definitions of EBP.**

1) An approach to decision-making in which the clinician uses the best evidence available (Muir Gray, 1997).

2) Conscientious and judicious use of current best evidence in making decisions about the care of individual patients (Sackett, 1997).

Definitions:

- ***Evidence Based:*** "Process by which nurses make clinical decisions using best available evidence, clinical expertise, patient preferences in the context of available resources".

- ***Evidence-based practice (EBP):*** Is the conscientious integration of best research evidence with clinical expertise and patient values and needs in the delivery of quality, cost-effective health care.
- ***Evidence -based psychiatric nursing:*** evidence-based practice is an ongoing process that strengthens psychiatric nursing and improves the quality of life for patients with mental illness values.

Evidence based practice

- In psychiatry, this focus extends to treatment approaches in which there is a scientific evidence for psychological and sociological treatment approaches as well as for evidence related to the neurobiology of psychiatric disorders and psychopharmacology

Evidence based practice

1- Do psychiatric nurses know the **efficacy** of their treatments and interventions?

2- Is the care they provide based on **evidence**?

3- Are they documenting the nature and **outcomes** of their nursing care?

* The **answers** to these questions are important in determining the **contributions** that they will make to mental health care.

Evidence based practice

Nurses cannot rely on traditional practices, opinion-based processes, or un proven theories. They need to question their current practices and find ways to improve patient care. To do this nurses must research literature, critically analyze research findings and apply relevant evidence to practice.

History of the EBP movement:-

The EBP movement was founded by Dr. Archie Cochrane, a British epidemiologist, who struggled with the effectiveness of health care and challenged the public to pay only for care that had been empirically supported as effective (Enkin, 1992)

History of the EBP movement:-

In 1972, Cochrane was a strong proponent of using evidence from RCTs because he believed that this was the strongest evidence on which to base clinical practice treatment decisions.

He asserted that review of research evidence across all specialty areas need to be prepared systematically through a rigorous process and that they should be maintained to consider the generation of new evidence

History of the EBP movement:-

In2000, Sackett, Straus, Richardson, and Haynes defined EBP as the use of conscientious use of current best evidence in making decisions about patient care. Since then, the definition of EBP has been broadened in scope and referred to as a lifelong problem solving approach to clinical practice that integrates:-

Components of evidence based nursing practice:-

Elements of EBP

- **Based on:**
  1. systematic search for and appraisal of most relevant evidence to answer questions
  2. one's clinical experience and expertise
  3. patient preference and values

The three elements are interrelated, if there is lack of congruence, the outcomes for the individual patient are likely to be affected

1-Asystematic search for as well as critical appraisal and synthesis of the most relevant and best research to answer a burning clinical question

2-One, s own clinical expertise

3- Patient preference and value

1 Best Scientific Evidence

External evidence from Research, Evidence-Based Theories, Opinion Leaders, and Expert.

2 Clinical Experience

Internal evidence generated from outcomes management or quality improvement projects, a through patient assessment and evaluation, and use of available resources.

3-patients's preference

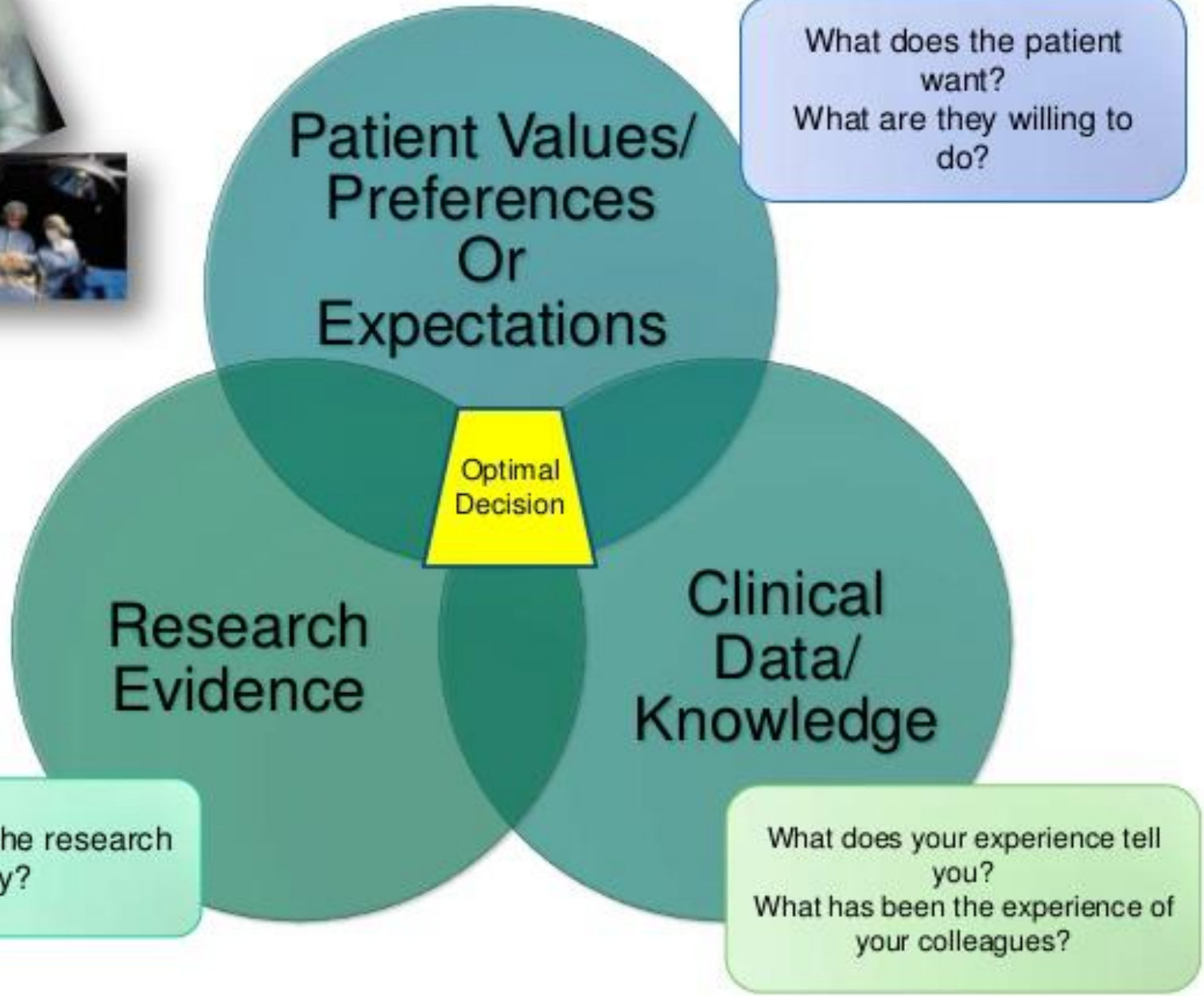
- Satisfaction ,quality of life and values.

Research evidence

Clinical expertise

Evidence-based practice

Patient values


Patient Values/ Preferences Or Expectations
What does the patient want?
What are they willing to do?
Optimal Decision
Research Evidence
What does the research say?
Clinical Data/ Knowledge
What does your experience tell you?
What has been the experience of your colleagues?

Purpose of EBP in psychiatric nursing

- Improve our ability to communicate with the treatment team. It is more effective to tell the treatment team that a patient's score on the Beck Depression Inventory has increased from x to y than to say "the patient looks more depressed."
- Explain what psychiatric nurses do, defining our role and contribution to the treatment team as we describe how we assess, monitor, and treat psychiatric symptoms and illness.

- Demonstrate the effect of our work on patient outcomes. When we can provide objective data that a nursing intervention has improved patients' symptoms or illness, our credibility and value are more evident to the treatment team.
- Guide our nursing interventions. Research has repeatedly demonstrated that we cannot assume what a patient is experiencing.

- Provide a standardized method for consistently tracking changes in patients' symptoms or illness over time.
- Research evidence guides us in finding the answers to our clinical questions. A clinical practice question may arise in the process of daily care delivery. Why does a particular practice continue? Is there evidence to support it? After a literature search, the psychiatric nurse may see what evidence actually supports or refutes that practice.

What are the benefits of EBP ?

For patients / consumer:

1) Assures patient receives most up-to-date care possible.
2) Allows patient and practitioner to work together to make informed decisions.
3) It results in better patient outcomes.

For nurses

- Provide practicing nurses with evidence-based data.
- helps nurses provide high-quality patient care based on research and knowledge.
- Assists practitioner in dealing with increasing volume of medical literature.
- It increases confidence in decision-making
- Provide nurses with rational of decisions and care plan

For health care organizations

- Allows for health organization to put themselves in the market as a quality institution.
- Policies and procedures are current and include the latest research, thus supporting JCAHO-readiness.

For the community

- Avoidance of wasting recourses on the delivery of ineffective interventions.
- Limit the amount of disability and suffering in the community

Evidence -based nursing versus nursing research utilization:-

Evidence based nursing practice	Nursing research utilization
Newer concept	Older concept
The purpose of EBNP to translate the evidence and applying it to the clinical decision- making	The purpose of research is to generate new knowledge or to validate knowledge based on theory
Evaluation of cost effectiveness	Cost not address

Include patient preferences and values	**Patient preference not included**
Use knowledge based on multiple studies and combine it with expertise of the practitioner	Use of knowledge based on single study
Evaluation of evidence based on clinical setting	Clinical setting not consider

Barriers to Evidence-Based Practice Utilization in Psychiatric/Mental Health nursing:

- Repeatedly, lack of time is identified one of the most crucial barriers to implementing evidence-based practice in the workplace (Bradshaw, 2010). Other documented barriers include:

1. Barriers related to nurse characteristics:

- Lack of the knowledge needed to interpret statistical analyses.
- Lack of interest.
- Lack of confidence in critical appraisal skills.
- Lack of knowledge and skills to confidently conduct computer based literature searches and utilize the research process.

- Nurses feeling overwhelmed by the volume of evidence.
- Nurses' perceptions that they lack the authority and cooperation to change patient care procedures.
- Negative beliefs, attitudes and values; and Educational preparation.

Barriers related to organizational characteristics:

- Limited or lack of time.
- Heavy patient workloads.
- Inadequate staffing.
- Limited access to resources.

- Lack of support from nurse managers.
- Different goals for practice between administrators and staff nurses.
- Lack of evidence-based practice mentors in health-care systems.

Barriers related to nature of research information:

- Research is seen as too complicated, too scholarly, excessively statistical, ambiguous, and having limited or no relevance to practice.
- Research reports lack clear practice implications and generalizability.

Barriers related to health-care environment:

- Multiple barriers have contributed to the slow uptake of EBP across healthcare systems…traditional approaches to teaching healthcare students the rigorous process of how to do research rather than how to use research to guide best practice.

Strategies to promote evidence-based practice / evidence-informed decision-making by psychiatric nurses

- Provide psychiatric nurses with “access to a rich library with nursing and mental health journals.
- Provide psychiatric nurses with “opportunities for working with a computer and for searching the Internet in the workplace.
- System support for searching and reading professional literature.

- Implementation of a virtual journal club.
- Provide psychiatric nurses with access to evidence-based practice resources via mobile information technologies.
- Implement an EBP mentorship programme with EBP mentors who are “skilled in both EBP and organizational culture and change.

- Support psychiatric nurses to acquire the skills needed to read, evaluate and critically appraise evidence.
- Establish leadership, a coherent change strategy, and relationships between point of care providers and managers.
- Nurse Managers act as role models.
- Nurse Managers “provide the resources and the support for the work and celebrate success with recognition of unit staff.

- Designate a champion who is accessible to the nurses, along with other leaders and innovators who can answer questions and reinforce the practice change.
- Involve the clinical educator as a part of the support system of the EBP change.

Evidence-based practice (EBP) in psychiatric-mental health nursing

- Evidence-based practice (EBP) in psychiatric-mental health nursing integrates current, high-quality research, clinical expertise, and patient preferences to improve outcomes. Key interventions include Cognitive-Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), motivational interviewing, and psychosocial rehabilitation. Evidence-based care often combines pharmacological management with therapeutic, holistic support.

Evidence-based practice (EBP) in psychiatric-mental health nursing

- **Key Evidence-Based Interventions:**
- **Cognitive Behavioral Therapy (CBT):** Treats depression, anxiety, and psychosis by challenging negative thought patterns.
- **Dialectical Behavior Therapy (DBT):** Effective for borderline personality disorder and emotional regulation.
- **Psychosocial Rehabilitation:** Focuses on functional recovery and community reintegration for severe mental illness.
- **Motivational Interviewing:** Enhances treatment adherence, particularly in substance use disorders.
- **Non-pharmacological Techniques:** Including relaxation exercises and positive imagery for stress reduction.

Cognitive Behavioral Therapy (CBT)

- Cognitive Behavioral Therapy (CBT) is a widely used therapeutic approach that focuses on the **relationship between thoughts, feelings, and behaviors**. It is based on the premise that our thoughts influence our emotions and actions, and by changing our thought patterns, we can change how we feel and behave.

Cognitive Behavioral Therapy (CBT)

- In psychiatric nursing, CBT offers structured frameworks to address distorted cognitions and unhelpful behaviors. It bridges psychological theory with practical nursing care — empowering patients to take an active role in recovery.

Definition of Cognitive Behavioral Therapy (CBT)

- **A form of psychotherapy that focuses on the relationship between thoughts, feelings, and behaviors. It is based on the idea that our thoughts influence our emotions and actions, and by changing our thought patterns, we can change how we feel and behave.**
- In CBT, therapists work collaboratively with clients to **identify and challenge negative or distorted thinking patterns that contribute to emotional distress and behavioral problems**. By examining and restructuring these maladaptive thoughts, individuals can develop more adaptive ways of thinking and responding to situations.

Historical Background of (CBT)

1. Aaron T. Beck (1960s): Developed cognitive therapy for depression.
2. Albert Ellis (1950s): Rational Emotive Behavior Therapy (REBT).
3. Behaviorism Roots: Pavlov (classical conditioning), Skinner (operant conditioning).
4. Integration of cognitive and behavioral approaches → CBT.

Theoretical Base of (CBT) in Depth

- **Cognitive Theory (Beck)**
- Thoughts influence emotions and behaviors.
- Core schemas → Automatic thoughts → Emotional & behavioral reactions.
- Negative cognitive triad: self, world, future.
- Changing maladaptive thoughts improves mood and actions.
- **Behavioral Theory (Pavlov, Skinner)**
- Behavior shaped by learning and reinforcement.
- Classical conditioning: associations create emotional responses.
- Operant conditioning: reinforcement and avoidance maintain maladaptive behavior.
- Exposure and behavioral activation break avoidance cycles.

Theoretical Base of (CBT) in Depth

Social Learning Theory (Bandura)

- Behavior learned through observation and modeling.
- Seeing others rewarded encourages imitation (vicarious learning).
- Self-efficacy—belief in one's ability—is key to change.
- Nurses can model adaptive coping and emotional regulation.

Theoretical Base of (CBT) in Depth

- CBT integrates these theories to create a holistic model of human behavior. While **cognitive** theory focuses on **changing thought patterns, behavioral theory targets learned responses through practice and reinforcement**. Social learning adds the understanding that people learn not only through experience but also by observing others. Together, these frameworks make CBT both practical and effective for promoting lasting change in mental health settings.

Cognitive Model Diagram

Cognitive Techniques

- •**Thought Records:** Encourage clients to document automatic thoughts linked to emotional reactions (e.g., "I failed the test → I'm useless").
- **Cognitive Restructuring:** Challenge and replace distorted thinking with balanced alternatives (e.g., "One failure does not define my worth").
- **Identifying Cognitive Distortions:** Recognize patterns such as:
  - *All-or-nothing thinking* — "If I'm not perfect, I'm a failure."
  - *Catastrophizing* — "If I make a mistake, everything will go wrong."
  - *Overgeneralization* — "I was rejected once, so no one will ever like me."

Behavioral Techniques

- **Exposure Therapy:** Gradual confrontation with feared stimuli.
- **Behavioral Activation:** Scheduling rewarding activities to counter depression.
- **Relaxation Training:** Deep breathing, progressive muscle relaxation.

Behavioral strategies help break the avoidance cycle common in anxiety and depression. Nurses can coach and reinforce these behaviors in daily routines.

Behavioral Techniques

- **1. Exposure Therapy – Example**

A client with Obsessive–Compulsive Disorder (OCD) who constantly washes their hands due to fear of contamination.

Application:

Step 1: Touch a clean object (like a book) and delay hand washing for 2 minutes.

Step 2: Touch a doorknob and wait 5 minutes before washing.

Step 3: Progress to touching commonly shared items and waiting longer. Over time, anxiety decreases, and the urge to perform compulsions weakens.

Nurse's Role: Reassure the client during exposure, track anxiety levels, and reinforce progress — showing that anxiety naturally decreases without rituals.

Behavioral Techniques

- **2. Behavioral Activation – Example**

A client with postpartum depression who has lost interest in daily life and feels isolated.

Application: The nurse helps the client plan small, meaningful tasks: Sit outside in the sunlight with the baby for 10 minutes.

Listen to favorite music or cook a simple meal.

Schedule one social visit with a supportive friend per week.

Each completed activity provides positive reinforcement, improving mood and engagement.

Nurse's Role: Provide encouragement, monitor mood changes, and adjust activities to match energy levels and motivation.

Behavioral Techniques

- **3. Relaxation Training – Example**

A patient with post-traumatic stress disorder (PTSD) who experiences muscle tension and flashbacks when reminded of trauma.

Application: The nurse teaches progressive muscle relaxation (PMR):Tense and relax muscle groups while focusing on breathing.

Combine with grounding exercises like noticing objects in the room to stay in the present moment.

Regular practice reduces physiological arousal and increases the sense of control during triggers.

Nurse's Role: Guide sessions, provide a calm environment, and encourage daily practice. The nurse also evaluates which relaxation methods (breathing, PMR, visualization) work best for the individual.

Third-Wave CBT Approaches

- **Mindfulness-Based Cognitive Therapy (MBCT)** — awareness of thoughts without judgment.
- **Acceptance and Commitment Therapy (ACT)** — psychological flexibility, values-based action.
- **Dialectical Behavior Therapy (DBT)** — emotion regulation, distress tolerance, interpersonal effectiveness.

These “third-wave” therapies expand CBT’s scope to include mindfulness, acceptance, and emotion regulation — essential for complex psychiatric conditions like borderline personality disorder.

Third-Wave CBT Approaches

1. Mindfulness-Based Cognitive Therapy (MBCT): MBCT combines mindfulness (being aware of the present moment) with traditional CBT techniques.

It helps people notice their thoughts and feelings without judging or reacting to them. Instead of trying to stop negative thoughts, clients learn to observe them and let them pass.

Example: A client who feels “I’m worthless” learns to notice that thought, take a breath, and remind themselves that it’s just a thought — not reality. This reduces rumination and relapse in depression.

Third-Wave CBT Approaches

2. Acceptance and Commitment Therapy (ACT): ACT teaches clients to accept what they cannot control (like painful emotions) and commit to actions that reflect their values.

The focus is not on removing symptoms but on living a meaningful life despite them.

Example: Someone with social anxiety may still attend a family event because connecting with loved ones is important to their values — even if they feel anxious while doing so.

Third-Wave CBT Approaches

3. Dialectical Behavior Therapy (DBT): DBT was developed for people with intense emotions, especially those with borderline personality disorder.

It helps balance acceptance and change, teaching clients how to regulate emotions, tolerate distress, and build healthy relationships.

Example: When a client feels angry, instead of shouting or self-harming, they might use a DBT skill such as deep breathing, self-soothing, or calling a support person.

Third-Wave CBT Approaches

Approach	Core Focus	Example of Use	Nursing Role
MBCT	Mindful awareness, preventing relapse	Depression relapse prevention	Teach mindfulness, monitor mood awareness
ACT	Acceptance & values-based action	Chronic anxiety, pain, PTSD	Guide value-based goal setting
DBT	Emotion regulation & distress tolerance	Borderline Personality Disorder	Reinforce skills, model calm responses

CBT Applications to Psychiatric Disorders

- **Depression:** Cognitive restructuring, behavioral activation.

Anxiety: Exposure therapy, cognitive reframing.
PTSD: Trauma narrative, cognitive reappraisal.
OCD: Exposure and Response Prevention (ERP).
Bipolar Disorder: Relapse prevention, early warning signs.
Schizophrenia: Reality testing, coping with voices.
Substance Use Disorders: Trigger recognition, relapse prevention.
Eating Disorders: Body image correction, cognitive control.
Insomnia: Sleep hygiene, relaxation, stimulus control.

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Each disorder demands tailored CBT techniques. Adapt strategies to patient readiness, culture, and cognitive level.

CBT Applications to Psychiatric Disorders, cont.

1. Depression

Goal: To reduce negative thinking, increase positive behaviors, and improve mood.

Applied: CBT focuses on identifying negative thoughts and encouraging engagement in rewarding activities.

Cognitive Technique: Cognitive restructuring helps the client challenge negative beliefs.

Example: A client thinks, “I’m worthless.” helping find evidence against it and replace it with “I have value and strengths.

Behavioral Technique: Behavioral activation encourages participation in enjoyable or meaningful tasks.

Example: The client plans a daily walk or meets a friend for coffee to improve motivation and energy.

CBT Applications to Psychiatric Disorders, cont.

2. Anxiety Disorders

Goal: To reduce excessive worry, avoidance, and physical symptoms of fear.

Application: CBT teaches clients to face fears gradually and replace irrational thoughts with realistic ones.

Cognitive Technique: Cognitive reframing — identify and modify catastrophic thoughts. Example: Instead of "Everyone will think I'm stupid," the client learns to think, "Everyone makes mistakes when speaking — that's okay."

Behavioral Technique: Exposure therapy — gradual exposure to feared situations.

Example: A client with social anxiety starts by greeting one person, then speaking briefly in class.

CBT Applications to Psychiatric Disorders, cont.

- **3. Post-Traumatic Stress Disorder (PTSD)**
- **Goal:**

  To reduce trauma-related distress, avoidance, and negative beliefs about the self or world.
- **Application:** CBT helps clients process traumatic memories safely and change unhelpful meanings attached to the trauma.
- **Cognitive Technique:** Cognitive reappraisal — correcting distorted guilt or shame thoughts.
- Example : The client replaces “It was my fault” with “I did the best I could in a dangerous situation.”
- **Behavioral Technique:** Trauma narrative/exposure — gradually recounting the traumatic event to reduce emotional power.
- Example: A client writes or discusses their trauma in therapy to face memories safely.

CBT Applications to Psychiatric Disorders, cont.

- **4. Obsessive–Compulsive Disorder (OCD)**
- **Goal:** To weaken obsessive thoughts and stop compulsive behaviors.
- **Application:** CBT uses structured exposure exercises and prevention of ritual responses.
- **Cognitive Technique:** Cognitive restructuring to challenge exaggerated responsibility.
- Example: The client replaces “If I don’t wash, I’ll get sick and die” with “My body can handle small amounts of germs.”
- **Behavioral Technique:** Exposure and Response Prevention (ERP) to reduce anxiety without rituals.
- **Example:** A client touches a doorknob and delays washing hands. Over time, anxiety decreases naturally.

CBT Applications to Psychiatric Disorders, cont.

- **5. Bipolar Disorder**
- **Goal:** To prevent relapse, manage mood swings, and recognize early warning signs.
- **Application:** CBT helps patients monitor thoughts, behaviors, and triggers while promoting balanced daily routines.
- **Cognitive Technique:** Identifying early warning thoughts ("I can do anything!" during hypomania).
- Example: A client learns to challenge risky thoughts during mania ("I don't need sleep") with reality-based thinking ("Lack of sleep can trigger relapse").
- **Behavioral Technique:** Relapse prevention planning — maintaining sleep, structure, and support.
- Example: Behavioral: Using a daily mood chart and contacting the nurse when early signs appear.

CBT Applications to Psychiatric Disorders, cont.

- **6. Schizophrenia**
- **Goal:** To improve reality testing, reduce distress from hallucinations, and enhance functioning.
- **Applied:** CBT helps patients identify unhelpful beliefs about voices and develop coping strategies.
- **Cognitive Technique:** Reality testing — questioning delusional beliefs.
- Example**:** A patient believes their neighbors are sending them threatening messages through the walls. Using Reality testing through behavioral experiments. The therapist and patient agree to test this belief by listening together at specific times and noting what they actually hear. They record observations over several days. The client realizes that no messages are actually heard, and the noises are consistent with normal environmental sounds.
- **Behavioral Technique:** Coping with voices — using distraction or relaxation techniques.
- Coping strategy example: Listening to music or talking with the nurse to shift focus from hallucinations.

CBT Applications to Psychiatric Disorders, cont.

- **7. Substance Use Disorders**
- **Goal:** To reduce cravings, prevent relapse, and promote healthy coping mechanisms.
- **How Applied:** CBT identifies triggers for substance use and teaches alternative responses.
- **Cognitive Technique:** Identifying and reframing craving-related thoughts.
- Example: The client challenges “I can’t relax without drinking” by replacing it with “Relaxation can come from exercise or music.”
- **Behavioral Technique:** Relapse prevention through coping plans and lifestyle change.
- Example**:** When craving occurs, the client calls a sponsor or practices deep breathing instead of using substances.

CBT Applications to Psychiatric Disorders, cont.

- **8. Eating Disorders**
- **Goal:** To change distorted body image and normalize eating patterns.
- **How Applied:** CBT challenges perfectionistic or distorted beliefs about food and body shape.
- **Cognitive Technique:** Cognitive restructuring — correcting distorted body thoughts.
- Example: The client replaces “I must be thin to be loved” with “My worth is not defined by my body.”
- **Behavioral Technique:** Exposure and meal monitoring — eating with support to reduce anxiety.
- **Example:** Eating regular meals while practicing positive affirmations in front of a mirror.

Factors Determining CBT Session Frequency and Duration

- Session frequency and duration in CBT depend on the **disorder's severity**, **client readiness**, **therapy goals**, **model used**, **setting**, and **progress rate**.

  Nurses and therapists must individualize the schedule to balance clinical effectiveness and client capacity.

Implementation Challenges in Nursing

- **Time constraints in busy wards** — limited opportunities for structured sessions.
- **Limited formal CBT training** among nurses.
- **High caseloads and heavy documentation** burden reduce therapeutic time.
- **Need for supervision and institutional support** to maintain quality and confidence.
- **Resource limitations** — lack of private space or digital tools for therapy.
- **Interdisciplinary coordination issues** — unclear role boundaries in mental health teams.

Despite proven benefits, practical barriers exist. Addressing these through training and policy support enhances CBT integration.

Ethical Considerations in CBT Practice

- **Informed consent & confidentiality** — ensure client understanding and privacy.
- **Avoiding coercion in behavior modification** — promote voluntary participation.
- **Cultural humility & respect for autonomy** — adapt interventions sensitively.
- **Maintain professional boundaries** in nurse–patient relationships.
- **Competence and supervision** — practice within training and seek guidance.

Role of the Nurse in CBT

- Psychiatric nurses play a vital role in addressing the interaction between a patient's thoughts, emotions, and behaviors. During assessment, nurses **identify negative automatic thoughts, emotional triggers, and maladaptive coping styles that contribute to psychological distress.**
- Provide psycho education through **explaining how thoughts influence emotions and behaviors**—and **teach practical skills such as thought monitoring and cognitive restructuring**. By supporting behavioral experiments, nurses help patients **test unhelpful beliefs in real-life situations, fostering insight and adaptive coping**.

Role of the Nurse in CBT

- Nurses also integrate CBT principles within the nursing process (ADPIE)—from assessing cognitive and behavioral patterns to planning interventions and evaluating outcomes. They use CBT-informed nursing diagnoses such as ineffective coping or distorted thought processes to guide care plans that target both psychological and behavioral change. Collaboration with psychologists and psychiatrists ensures that CBT interventions are consistent with broader treatment goals, such as medication management or crisis stabilization.
- Through education, support, and multidisciplinary teamwork, nurses could empowering clients to build healthier thought patterns and improve emotional well-being.

Nursing Process Integration

Step	CBT Application	Focus Points
Assessment	• Identify maladaptive thoughts & behaviors	• Explore thought–feeling–action links • Use thought records/interviews
Diagnosis	• Define cognitive-related problems	• Ineffective coping • Distorted thinking patterns
Planning	• Set collaborative goals	• Target specific thoughts or behaviors • Plan measurable outcomes
Implementation	• Apply CBT interventions	• Cognitive restructuring • Exposure & relaxation • Behavioral activation
Evaluation	• Review progress & outcomes	• Track symptom changes • Modify plan as needed

Dialectical Behavior Therapy (DBT) for Borderline Personality Disorder (BPD) and self-harm

- **What is DBT?**
- **Dialectical Behavior Therapy (DBT)** is a structured, skills-based psychotherapy originally developed for people with **borderline personality disorder**, especially those with **chronic self-harm, suicidal behavior, severe emotional dysregulation, and unstable relationships**. NICE describes DBT as an intensive psychological treatment that helps the person build skills to regulate emotions and behavior, and notes that it usually runs for about **1 year** with **weekly individual and group sessions**.

Dialectical Behavior Therapy (DBT) for Borderline Personality Disorder (BPD) and self-harm

- The word **dialectical** means working with two truths at the same time:
- **acceptance** of the patient as they are right now
- **change** in the behaviors that are causing harm
- That balance is the whole engine of DBT. It does not shame the patient for self-harm, and it does not excuse harmful behavior either. It says, in effect: *you are doing the best you can, and you still need to learn safer, more effective ways to cope*. This acceptance-plus-change framework is one of the reasons DBT is especially suitable for BPD.

Dialectical Behavior Therapy (DBT) for Borderline Personality Disorder (BPD) and self-harm

Why is DBT used in BPD?

- BPD is associated with:
- intense and rapidly shifting emotions
- impulsivity
- unstable self-image
- unstable relationships
- recurrent self-harm and suicidal behavior
- A recent clinical summary notes that psychotherapy is the **primary treatment modality** for BPD, and recent guideline synthesis says clinicians should optimize psychotherapy before moving toward unnecessary medication escalation.
- DBT is one of the best-known and most studied psychotherapies for this group. A 2024 systematic review reported that DBT **reduces suicidality and self-injurious behaviors** in patients with BPD. A 2024 comprehensive review also reported that DBT reduces **self-harm, suicidality, and depressive symptoms**, with benefits that may persist after treatment ends.

Dialectical Behavior Therapy (DBT) for Borderline Personality Disorder (BPD) and self-harm

Why is DBT especially useful for self-harm?

- Many patients with BPD do not self-harm "for attention," despite the lazy myth that still floats around clinical settings like bad coffee. Self-harm is often used to:
- reduce unbearable emotional intensity
- escape dissociation or numbness
- express distress that feels impossible to verbalize
- regain a sense of control
- punish the self
- DBT directly targets these functions. Instead of only telling the patient to stop self-harming, it teaches **alternative coping skills** that can regulate distress more safely and effectively. The evidence base supports DBT for reducing both **non-suicidal self-injury** and **suicidal/self-directed violence** in BPD populations.

Dialectical Behavior Therapy (DBT) for Borderline Personality Disorder (BPD) and self-harm

Main goals of DBT

- DBT usually aims to:
- reduce life-threatening behaviors, including suicide attempts and severe self-harm
- reduce therapy-interfering behaviors, such as dropping out, severe avoidance, or repeated non-engagement
- reduce quality-of-life-interfering behaviors, such as substance misuse, impulsivity, or destructive relationship patterns
- build behavioral skills for a more stable and meaningful life
- That hierarchy matters. In DBT, **safety comes first**. You do not start polishing abstract insight while the patient is actively bleeding emotionally or physically.

Dialectical Behavior Therapy (DBT) for Borderline Personality Disorder (BPD) and self-harm

Core components of DBT

- Standard DBT is not just one weekly chat. It is a **multicomponent treatment**. The classic model usually includes:
- **1) Individual therapy**
- This is where the therapist and patient work on:
- recent crises
- self-harm urges and incidents
- suicidal thoughts
- treatment goals
- applying DBT skills to real-life problems
- A major tool here is **behavioral chain analysis**, where the patient and therapist examine, step by step:
- what happened before the self-harm
- what thoughts, feelings, body sensations, and events built up
- what vulnerability factors were present
- what the short-term payoff of self-harm was
- what skills could have been used instead next time
- This makes self-harm understandable and treatable, not mysterious.

Dialectical Behavior Therapy (DBT) for Borderline Personality Disorder (BPD) and self-harm

2) Skills training group

- Patients are taught practical skills in a group format. These are the famous four DBT skill modules:
- **a) Mindfulness**
- This teaches the patient how to:
- notice thoughts and emotions without immediately reacting
- stay in the present moment
- reduce automatic, impulsive responding
- Mindfulness is foundational because many BPD crises escalate fast. If the patient cannot notice the emotion rising, they cannot intervene before self-harm becomes the default coping response.

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Dialectical Behavior Therapy (DBT) for Borderline Personality Disorder (BPD) and self-harm

- **b) Distress tolerance**
- These skills help the person survive a crisis **without making it worse**. They are used when emotions are too high for deeper processing.
- **Examples include:**

➢ **distraction strategies**

➢ **grounding**

➢ **self-soothing**

➢ **crisis survival methods**

➢ **urge management**

➢ **This is the module most directly relevant to self-harm because it gives the patient emergency alternatives when the urge hits hard.**

Dialectical Behavior Therapy (DBT) for Borderline Personality Disorder (BPD) and self-harm

c) Emotion regulation

- These skills help patients:
- identify emotions accurately
- reduce emotional vulnerability
- understand what triggers emotional escalation
- respond in ways that fit the situation
- This matters because BPD is often marked by **high emotional sensitivity**, **intense emotional responses**, and **slow return to baseline**. DBT aims to make emotions more manageable, not eliminate them.

d) Interpersonal effectiveness

- These skills help with:
- setting boundaries
- asking for needs effectively
- saying no
- reducing relationship chaos
- maintaining self-respect in conflict
- Because many crises in BPD are triggered by perceived rejection, abandonment, or invalidation, interpersonal skills are not “extra”; they are relapse prevention.

Dialectical Behavior Therapy (DBT) for Borderline Personality Disorder (BPD) and self-harm

- **3) Between-session coaching**
- In standard DBT, patients may receive brief coaching to help them use DBT skills **in the moment**, before acting on self-harm urges. The goal is not dependency; it is real-time skill generalization. NICE's description of DBT as an intensive treatment is consistent with this broader, skills-focused structure. (NICE)
- **4) Therapist consultation team**
- DBT also includes support for therapists. This is important because work with chronic suicidality, self-harm, splitting, dropout risk, and emotional intensity can burn clinicians out. The consultation team helps maintain treatment fidelity and clinician effectiveness. This component is part of why DBT is more than generic supportive therapy. (PMC)

Dialectical Behavior Therapy (DBT) for Borderline Personality Disorder (BPD) and self-harm

- **How does DBT reduce self-harm?**
- DBT reduces self-harm through several linked mechanisms:

1-It teaches replacement behaviors

- Instead of cutting, overdosing, burning, or hitting walls, the patient learns concrete distress-tolerance skills that serve a similar short-term regulatory function with less harm. (PMC)

2-It identifies triggers and patterns

- Patients learn to map the sequence leading to self-harm, including:
- sleep deprivation
- conflict
- shame
- substance use
- abandonment fears
- invalidating encounters
- Once the pattern is visible, it becomes interruptible.

Dialectical Behavior Therapy (DBT) for Borderline Personality Disorder (BPD) and self-harm

3-It reduces black-and-white thinking

- BPD often involves all-or-nothing appraisals:
- “They hate me.”
- “I ruined everything.”
- “I can’t survive this feeling.”

  DBT helps patients hold more than one truth at a time, which reduces crisis intensity.

4-It improves the therapeutic alliance

- Patients with BPD often expect rejection, punishment, or misunderstanding. DBT’s validating stance can improve engagement and reduce dropout, which matters because a treatment only works if the patient stays in it long enough to benefit.

Dialectical Behavior Therapy (DBT) for Borderline Personality Disorder (BPD) and self-harm

- **Role of the mental health nurse in DBT**
- Even when the nurse is not the primary DBT therapist, nursing practice is still central.
- **The nurse helps with:**
- risk assessment for suicide and self-harm
- recognizing early warning signs
- reinforcing DBT skills between formal sessions
- maintaining a validating, nonjudgmental stance
- reducing punitive or shaming responses to self-harm
- supporting safety planning
- monitoring treatment adherence and engagement
- helping the patient use skills during acute distress
- documenting patterns, triggers, and responses
- In inpatient or crisis settings, nurses may be the professionals who see the patient **at the exact moment urges escalate**, which makes their role crucial in translating DBT from theory into real-world containment and skill use. NICE self-harm guidance also emphasizes the need for information, support, and appropriate psychosocial intervention rather than simplistic management of the injury alone.

Dialectical Behavior Therapy (DBT) for Borderline Personality Disorder (BPD) and self-harm

DBT versus "ordinary supportive counseling"

- This difference is exam gold.
- DBT is not just:
- listening kindly
- offering reassurance
- telling the patient to calm down
- advising them not to self-harm again
- DBT is a **structured, manualized, behavioral treatment** with clear targets, explicit skills modules, ongoing monitoring, and a strong emphasis on measurable change in dangerous behaviors.

Dialectical Behavior Therapy (DBT) for Borderline Personality Disorder (BPD) and self-harm

- **Limitations and practical challenges**
- DBT is effective, but it is not easy to implement perfectly.
- **Common challenges include:**

➢ long duration and intensity

➢ need for trained staff

➢ service capacity limitations

➢ patient dropout risk

➢ complexity in highly comorbid patients

➢ Still, because self-harm and suicidality in BPD are so clinically significant, many services consider DBT worth the investment when available.

2) Motivational Interviewing (MI)

- **Motivational Interviewing** is a patient-centered communication approach used to strengthen a person's **internal motivation for change**. Instead of forcing the patient or confronting them harshly, MI helps the person explore ambivalence and discover their own reasons for improving. It is especially useful when the patient is resistant, unsure, or inconsistent in treatment engagement.
- **Uses:**
- Addiction
- chronic illness
- poor adherence to treatment
- behavioral change difficulties

2) Motivational Interviewing (MI)

- **Main principles:**
- expressing empathy
- avoiding judgment
- supporting self-efficacy
- helping the patient recognize the gap between current behavior and desired goals
- **Nursing role:**
- Mental health nurses use MI to:
- reduce patient resistance
- improve engagement with treatment
- support medication adherence
- encourage lifestyle or behavioral change
- create a supportive, respectful therapeutic relationship
- **Why it is important:**
- MI is highly effective in improving **compliance and treatment participation**, especially in patients who are not yet fully ready to change. That is why it is very useful in real clinical settings.

3) Medication Management

- **Medication management** is a major evidence-based intervention in psychiatric nursing because many serious mental health disorders require regular and correct use of psychotropic medication. The evidence in the file shows that proper medication adherence helps reduce **relapse**, especially in schizophrenia, bipolar disorder, and severe depression.
- **Uses:**
- Schizophrenia
- Bipolar disorder
- Severe depression
- Other chronic psychiatric conditions

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4) Trauma-Informed Care (TIC)

- **Trauma-Informed Care** is an approach that recognizes that many psychiatric patients have a history of trauma, even if it is not immediately obvious. This means care should always be delivered in a way that promotes **safety, respect, and emotional protection**, while avoiding actions that may retraumatize the patient.
- **Main goals:**
- safety
- trust
- respect
- empowerment
- avoiding retraumatization

4) Trauma-Informed Care (TIC)

Nursing role:

- The nurse applies TIC by:
- communicating calmly and respectfully
- giving the patient choices whenever possible
- avoiding harsh, controlling, or humiliating behavior
- recognizing trauma reactions
- supporting patient empowerment
- listening actively and validating the patient's feelings

Why it is important:

- TIC is not just a style of kindness. It is an evidence-based framework that improves engagement, reduces distress, and helps patients feel secure in care settings. It is especially important because mental health services frequently care for patients with trauma histories

5) Psychoeducation

- **Psychoeducation** means educating patients and often their families about mental illness, treatment, medication, relapse signs, coping methods, and support systems. It is a practical and evidence-based intervention that strengthens the patient's ability to understand and manage the disorder.
- **Benefits:**

➢ reduces relapse

➢ reduces hospital admission

➢ improves self-management

➢ strengthens coping skills

➢ improves treatment understanding

5) Psychoeducation

Nursing role:

- The nurse often leads psychoeducation by teaching patients about:
- the nature of the disorder
- medication and side effects
- warning signs of relapse
- stress management
- available support resources

Why it is important:

- Psychoeducation improves patient knowledge, and patient knowledge improves adherence, coping, and outcomes. That is why it is commonly included in exams and clinical discussions

6) Mindfulness-Based Interventions

- Mindfulness-based interventions help patients focus on the present moment in a calm and nonjudgmental way. The file specifically mentions approaches such as:
- **MBSR** = Mindfulness-Based Stress Reduction
- **MBCT** = Mindfulness-Based Cognitive Therapy
- **Uses:**
- Anxiety
- Depression
- Chronic stress
- Emotional distress

6) Mindfulness-Based Interventions

Nursing role:

- Mental health nurses can teach or reinforce simple mindfulness practices such as:
- breathing exercises
- grounding techniques
- short meditation practices
- present-moment awareness during stress

Why it is important:

- Mindfulness is useful because it helps the patient regulate emotional reactions, reduce distress, and become less overwhelmed by triggers. It is also practical and relatively easy to integrate into routine nursing care.

7) Crisis Intervention

Crisis intervention is an essential evidence-based nursing practice used when the patient is in an acute psychiatric or emotional crisis. This may include suicidal thoughts, psychotic breakdown, aggression, severe panic, or extreme distress. The main purpose is immediate stabilization and safety.

- **Main elements:**
- rapid assessment
- de-escalation
- safety measures

7) Crisis Intervention

- **Nursing role:**
- The nurse is often on the front line, so the role includes:

- quickly assessing the seriousness of the crisis
- identifying risk to self or others
- using therapeutic communication
- reducing environmental triggers
- applying de-escalation strategies
- protecting the patient and staff
- following standardized emergency protocols when needed

7) Crisis Intervention

- **Why it is important:**
- This is not optional. It is a core mental health nursing competency because unsafe or delayed response in a crisis can lead to harm. Evidence-based crisis intervention helps manage emergencies effectively and safely

8) Recovery-Oriented Care

- **Recovery-oriented care** shifts mental health practice from only "reducing symptoms" to helping the patient build a **meaningful life**, with hope, autonomy, and empowerment. It focuses on what the person can achieve, not just what disorder they have.
- **Main focus:**

➢ meaningful life

➢ empowerment

➢ hope

➢ personal goals

➢ patient participation in care decisions

8) Recovery-Oriented Care

- **Nursing role:**
- The nurse supports recovery-oriented care by:
  - involving the patient in decision-making
  - encouraging goal-setting
  - respecting personal strengths
  - focusing on abilities as well as symptoms
  - promoting independence and community participation

Why it is important:

- This is a major conceptual shift in modern psychiatric care:

  from **“treat the illness”**

  to **“support the person in living well despite illness.”**

  That is why it is considered a highly important contemporary approach.

9) Behavioral Activation (BA)

- **Behavioral Activation** is a practical evidence-based intervention mainly used in depression. It works by helping the patient gradually increase engagement in **meaningful, rewarding, and structured activities**, even when motivation is low. Depression often causes withdrawal, inactivity, and avoidance, and BA directly targets these patterns.
- **Main aims:**

➢ increase activity

➢ reduce avoidance

➢ rebuild routine

➢ improve mood through action

9) Behavioral Activation (BA)

Nursing role:

- The nurse helps by:
- encouraging participation in small planned activities
- helping the patient set realistic behavioral goals
- reinforcing effort and progress
- monitoring the relationship between activity and mood

Why it is important:

- BA is one of the simplest but strongest tools for depression because it directly interrupts the cycle of inactivity and emotional decline. It is highly practical in everyday nursing work.

10) Collaborative Care

- **Collaborative care** is a team-based treatment model where different professionals work together to provide coordinated mental health care. The file identifies teamwork between the:
- nurse
- psychiatrist
- psychologist

and this model is especially useful in complex cases.

10) Collaborative Care

- **Why it is especially important in complex cases:**
- Complex cases often involve:

➢ more than one psychiatric diagnosis

➢ combined mental and physical illness

➢ social problems

➢ poor adherence

➢ repeated relapse

➢ multiple treatment needs at the same time

➢ A single clinician usually cannot manage all these dimensions alone.

10) Collaborative Care

Nursing role:

- The mental health nurse often acts as the key coordinator by:
- maintaining communication among team members
- following up referrals
- tracking progress
- ensuring continuity of care
- identifying problems early
- linking the patient with the right support services

Why it improves outcomes:

- Collaborative care reduces fragmentation. Instead of each professional working in isolation, care becomes integrated, organized, and patient-centered. That is why it is especially effective in complicated and long-term psychiatric conditions.
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Thank You!