It is imperative to provide culturally competent health care for adolescents experiencing mental distress and urologic problems. This article discusses mental health and illness perspectives within this cultural group, and delineates culturally competent nursing assessment and treatment strategies for adolescents 13 to 23 years of age.

Objectives

1. Discuss the connection of mental wellness, illness, and cultural competence in adolescents 13 to 23 years of age experiencing urologic problems.
2. Describe symptoms of the most prevalent mental illnesses (such as depression, anxiety disorder, eating disorder, and schizophrenia) that may emerge during the adolescent years.
3. Provide a list of rating scales that can be used by nurses to screen for possible depressive, anxiety, and disordered thought symptoms.

The Culture of Mental Illness in Adolescents with Urologic Problems

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Culture is an internal and external representation of a person’s belief and value systems (Warren, 2008a), and it represents the person’s essence. Adolescents are a unique cultural group and have several layers of culture that comprise their individual beliefs, values, norms, and health experiences. These layers may include but are not limited to developmental stage, chronological and emotional age, mental and physical health status, race, ethnicity, religion, sexual orientation, biological sex, group and/or community attachments, and environmental settings. Mental wellness is the foundation for overall quality health for an adolescent (Lutz & Warren, 2007; Warren, 2009).

Urologic problems may alter adolescent developmental and mental health processes, and possibly destabilize the quality of biopsychosocial health. Culturally competent nursing care uses a holistic approach to facilitate the stabilization of adolescent health. It is important for nurses caring for adolescents with urologic problems to understand the role of cultural variables on biopsychosocial health in their adolescent patients.

The purpose of this article is to:

- Discuss the connection of mental wellness, illness, and cultural competence in adolescents 13 to 23 years of age experiencing urologic problems.
- Describe symptoms of the most prevalent mental illnesses (such as depression, anxiety disorder, eating disorder, and schizophrenia) that may emerge during the adolescent years.
- Provide a list of rating scales that can be used by nurses to screen for possible depressive, anxiety, and disordered thought symptoms.

Key Words: Culture, cultural competence, adolescent, mental wellness, mental health, mental illness, urologic dysfunction, depression, anxiety, eating disorders.
es (such as depression, anxiety disorder, eating disorder, and schizophrenia) that may emerge during the adolescent years.

- Provide a list of rating scales that can be used by nurses to screen for possible depressive, anxiety, and disordered thought symptoms.
- Present case studies that emphasize the implementation of culturally competent nursing strategies for adolescents with urologic problems.

Role of Culture and Cultural Competence in the Care of Adolescents

According to current cultural literature and research, important and unique differences exist across all cultural and ethnic groups (Warren, in press; 2007). Cultural competence is the ongoing and developmental process whereby a nurse exhibits a level of proficiency in developing an awareness of the importance of culture for individuals, as well as understanding the importance of incorporating cultural needs into patient care (Warren, 2008b, 2009). Adolescents with urologic problems have several layers of culture; consequently, nurses need to be able develop culturally relevant nursing care plans that address each layer of culture in their adolescent patients. Culturally competent nursing interventions and strategies increase resilience and promote recovery for adolescents with urologic problems (Lutz & Warren, 2007).

Layers of Culture

Adolescence represents a time for change and transition. Each adolescent begins to culturally, intellectually, and physically move from being a child toward becoming an adult. It is a time when nurses can facilitate the launching of adolescents’ healthy biopsychosocial behaviors. Understanding adolescent layers of culture will also help clinicians develop culturally competent plans that successfully guide adolescents and their families back to a healthier state when illness has occurred.

Adolescent culture is grounded in developmental stages and the beliefs, values, and norms important to them. Cultural world view affects what adolescents value, and how they learn and interact with others. The cultural and ethnic environment an adolescent is reared in becomes the foundation from which his or her own beliefs, values, and norms develop. It is essential for nurses to assess and consult parents, guardians, and other significant individuals in the lives of adolescents when developing and evaluating nursing strategies, interventions, and protocols.

Process of Cultural Competence

The layering of other cultural variables, such as race, ethnicity, religion, sexual orientation, biologic sex, group and/or community attachments, and environmental settings, contributes to an adolescent’s expression of his or her culture. Culturally competent care begins with the realization that different cultures exist and that culture is important to adolescents and those who support them. Clinicians should be aware of the roles bias and stigma play in the lives of adolescent patients. Any pre-existing biases should be acknowledged and changed (Warren, 2011). Nurses should first assess, understand, and confront their own beliefs, values, and norms about adolescent cultural layers (Purnell, 2010). Nurses must formally educate themselves about the various cultural layers of adolescence (such as age and developmental stage, religious preference, sexual orientation, race, ethnicity, religion, or the presence of a mental disorder) (Warren, 2007). Such education is available through academic cultural courses, reading cultural literature, consulting with other culturally competent health care professionals and educators, and volunteering in culturally diverse settings (Purnell, 2010). The next step in becoming more culturally competent involves increasing encounters with culturally and ethnically diverse adolescents (Warren, 2002, 2011).

Additionally, recognizing the concept of world view and its role in interactions and relationships is essential because it affects how nurses and patients communicate with each other. Understanding similarities or differences in the preference or use of a particular world view facilitates the establishment of culturally competent nurse-patient relationships. There are four world views: systematic, relational, community, and eco-logic.

The systematic world view is grounded in analytic thought and reasoning. This is a common world view valued by nurses and other health care providers. A precise approach is used to conduct assessments and provide quality-effective care for patients. The relational world view places a high value on relationships and interactions with others. A patient wanting to establish trust and a relationship with a nurse may pose questions such as, “Are you married? Do you have children? How long have you been a nurse?” A person who primarily values the community view will seek the guidance of others (such as immediate family members, elders, shamans, ministers) from his or her community prior to implementing treatments and making health care decisions. Someone who espouses the ecologic view believes there is a connection between all persons and the environment. Moreover, everyone is responsible for maintaining connections and environments.

Culturally incompetent health care providers can negatively affect the biopsychosocial health of adolescents with urologic problems. They may express negative principles and communicate with
others in ways indicative of their biases regarding culturally and ethnically diverse adolescents. Expression of cultural incompetence (Warren, in press) intensifies the mental distress an adolescent with urologic problems is already experiencing. Nurses must understand the connection between culturally competent care and normal developmental processes in adolescent patients to reduce negative stress in adolescent patients. Adolescent mental health and wellness may be seriously compromised if negative stress is not minimized or eliminated (Antai-Otong, 2008).

**Emergence of Mental Disorders and Developmental Tasks**

**The Emergence of Mental Disorders**

Stress often increases for adolescents due to the completion of developmental tasks associated with this stage. This increase in stress places adolescents at risk for mental distress and possible mental illness. The incidence of adolescent mental health disorders is estimated at 10%, and the peak time for onset is 14 years of age (Medina, 2009; U.S. Department of Health and Human Services [DHHS], 2001). The formulation and development of brain gray matter and synaptic density begins during childhood, peaks during puberty, and matures during the late teens (Medina, 2009). Issues of insight, planning, and inhibition are formulated during early adolescence. These physical alterations and changes are normal. However, concomitant normal hormonal changes may alter an adolescent’s ability to behave and respond in an appropriate and consistent manner (Hamrin, Deering, & Scahill, 2008; Scahill, Hamrin, Deering, & Pachlar, 2008). This alteration can increase the level of stress an adolescent experiences, hamper the ability to function and interact with others, and interfere with successful completion of developmental tasks (Antai-Otong, 2008).

Risk factors for the possible development of mental health disorders include a combination of biopsychosocial factors. These factors may include genetic alterations due to injury during pregnancy and childbirth, as well as a family history of mental illness (Micucci, 2009; Wagner, 2009). Personal and/or social influences may also intensify the risk of mental illness. These influences include violence, abuse, poverty, unstable home and/or school environments, lack of health care access, alteration in health, and/or exposure to environmental toxins (Warren, 2008c).

Depression, anxiety, and eating disorders are the most frequently diagnosed mental health disorders during early and middle adolescence. The majority of these disorders are initially diagnosed by 14 years of age (DHHS, 1999; Hamrin et al., 2008). Early symptoms of mental disorders often appear two to four years prior to an actual diagnosis being determined (National Academies of Science, National Research Council, 2008). This early window of symptom immersion represents an excellent opportunity for nurses to intervene and help adolescents and their families and/or other support persons to strengthen coping strategies and develop overall mental health and wellness behaviors. In addition, early intervention during this time may decrease the severity of mental distress, decrease the level of symptoms associated with mental illness, and increase resilience and recovery for adolescent patients (Deering & Scahill, 2008).

**Developmental Tasks**

Adolescence denotes the developmental stage of identity versus role conflict. This stage is characterized by conflict, turmoil, and crisis as the adolescent struggles from childhood to adulthood (Antai-Otong, 2008). Each cultural and ethnic group has its own way of dealing with the behaviors adolescents exhibit during the identity and role stage. Emotions such as anger, self-absorption, and mood alterations may be either promoted or constrained based on accepted cultural norms to which the adolescent or family of origin adheres (Warren, 2008a). Nurses should assess how parents and others who are important to the adolescent approach the teen behaviors because this presents an opportunity to develop culturally relevant strategies of care (Antai-Otong, 2008). For the purpose of this article, the stage of adolescence is sub-divided into age categories: early (13 to 15 years of age), middle (16 to 18 years of age), and late (19 to 23 years of age).

**Early Adolescence and Mental Disorder Symptoms**

Adolescents in this category are beginning to develop abstract and formal operations thinking, but they continue to exhibit concrete thinking, self-involvement, self-preoccupation, and self-consciousness, which are hallmark behaviors of earlier developmental stages (Friedberg, McClure, & Garcia, 2009). Adolescents across all stages may normally exhibit secretive and defensive behaviors in their interactions with adults. These behaviors initially present in early adolescence and are related to the pubertal hormonal alterations and cognitive development (Deering & Scahill, 2008). The continuing development of peer relationships and interactions are important developmental processes for this age category. Any new or additional stressors, such as the death or loss of a loved one, presence or development of existing disease, or family instability, intensify a teen’s risk for the development of mental distress and possible subsequent mental illness.

**Indications of depressive disorder symptoms in adolescents.**
The presence of depressive symptoms changes an adolescent’s emotions, motivation, physical well-being, and thought processes. The normal developmental behaviors adolescents may exhibit (such as moodiness and/or less communication with parents, siblings, or some friends) are generally brief in duration and do not consistently impair the ability to appropriately interact with others on a daily basis. In addition, the normal emotional and relationship alterations are usually less than two weeks in duration and do not interfere with everyday functioning.

Manifestation of depressive symptoms is often the first indication that an adolescent’s overall mental health is deteriorating. Depressive symptoms associated with clinical depression (psychiatrically diagnosed) include sadness, tearfulness, feelings of worthlessness, changes in eating and/or sleeping habits, loss of interest in activities and/or relationships previously valued and enjoyed, and feelings of hopelessness that persist in intensity for longer than two weeks (American Psychiatric Association [APA], 2000). Adolescents who are depressed and/or anxious often resort to the use and abuse of alcohol and other substances (APA, 2000; Barlas, 2009; Hamrin et al., 2008; Medina, 2009). In addition, they may engage in other risky behaviors, including but not limited to discontinuing required treatments/medications, sexual promiscuity, dangerous driving practices, and forming relationships with people who are involved in criminal, violent, or abusive activities (Antai-Otong, 2008).

The most serious outcome of untreated clinical depression is suicide. Concern should be aroused when depressive symptoms are prolonged, intense, and/or accompanied by thoughts of self-harm or suicide. In addition, immediate attention and hospitalization is needed if an adolescent expresses self-harm or suicidal thoughts and/or actions.

There are four essential questions a nurse should ask if concerned about the adolescent’s safety. These questions are asked sequentially, and if the answer to a question is “No,” there is no need to continue. However, a nurse needs to continue to be vigilant about assessing for suicide in adolescents who are at risk. If the answer is “Yes,” continue to next question:

- Are you having thoughts of hurting yourself or others?
- Do you have a plan?
- Do you have access to carry out your plan?
- Are you planning to carry out your plan?

If the answer is yes to the last question, steps need to be taken to assure the safety of the adolescent. The most appropriate step is to have the adolescent escorted to an emergency room and be hospitalized for further psychiatric evaluation and treatment. Cognitive behavioral therapy and/or pharmacologic regimens are appropriate psychiatric interventions for adolescents who are clinically depressed.

**Indications of anxiety disorder symptoms in adolescents.** Anxiety is a common occurrence in the lives of adolescents. However, it should be transient and related to their current developmental tasks. Ongoing, increasing, and persistent symptoms of anxiety can interfere with the successful completion of developmental tasks and place adolescents at risk to develop other mental health disorders (Antai-Otong, 2008; Deering & Scahill, 2008). Anxiety disorders frequently occur concomitantly with other mental health disorders (APA, 2000). The prevalence of anxiety disorders in adolescent populations is reported to be anywhere between 2% to 4% for any occurrence. However, 6- and 12-month estimates are as high as 10% to 20%, respectively (Connolly & Nanayakkara, 2009). Anxiety disorders include separation and/or generalized anxiety, as well as obsessive-compulsive, post-traumatic stress, phobias, panic, and mutism varieties.

The expression of somatic symptoms is a common occurrence for adolescents who are anxious. These symptoms include headaches, stomach pain, muscle pain, appetite and sleep alterations, and restlessness. Nurses should assess for the presence and level of anxiety in adolescent patients. Use of rating scales for depressive and anxiety symptoms will be discussed in a later section of this article. Anxiety is a symptom that is present at some level for every adolescent who incurs mental distress (APA, 2000). Psychiatric interventions for anxiety include the use of cognitive behavioral therapy and/or pharmacologic intervention with SSRI medications (Connolly & Nanayakkara, 2009; Deering & Scahill, 2008).

**Middle Adolescence**

Teens in the middle years strive to establish their own identity separate from their family. Peer relationships that begin to have importance in the earlier teen years now dominate these middle years. Self-preoccupation continues, and sexual maturation and identity are significant milestones. Teens in this category struggle to find themselves as unique human beings, and they often alternate between wanting to be completely self-sufficient and wanting to be completely nurtured.

**Indications of eating disorder symptoms in adolescents.** Eating disorders often emerge during the middle years of adolescence. They present as either anorexia nervosa and/or bulimia nervosa. Anorexia nervosa begins later in the early category or early in the middle category, while bulimia nervosa usually emerges later in the middle category. Adolescents with anorexia nervosa appear moderately to severely under-
weight, and their weight does not correspond with generally accepted weight chart guidelines. Additional symptoms include pallor, loss of dental enamel, thinning hair, and listlessness. These adolescents eat little to nothing during the day and may also be extreme in their exercise regimens. Bulimia nervosa is characterized with eating large quantities of food and then relying on purging behaviors (such as the use of laxatives and vomiting).

**Late Adolescence**

This last category in adolescence is a time for completing the identity process and when most crises are resolved. Abstract thinking is achieved, and adolescents move into the intimacy versus isolation stage of young adulthood. Brain and cognitive maturity are finalized as adolescents determine who they are and begin their work and career foci.

**Indications of schizophrenia symptoms in adolescents.** Symptoms indicative of schizophrenia may begin during childhood years as autistic behaviors and then escalate during the adolescent years (Jensen, Kumra, Thomarios, & Williams, 2009). Changes in thinking processes and/or the presence of alterations in sensory perceptions (hallucinations, delusions, and illusions) may be symptoms indicative of schizophrenia. However, it is rare that schizophrenia is diagnosed during childhood or early adolescence due to the complicated nature of the disorder's symptoms and behaviors in conjunction with normal developmental stage changes. Generally, adolescent men are diagnosed somewhere between the ages of 19 to 20 years, while adolescent women are diagnosed in their early to late 20s (Warren & Antai-Otong, 2008).

**Physiologic Problems and Mental Distress**

The physiological changes experienced by adolescents may exacerbate the emotional changes they experience, and consequently, affect their overall mental health and wellness. Most adolescents progress through their developmental processes with few major problems (Rubin, Bukowski, & Laursen, 2009). However, they may still engage in risk-taking behaviors and/or have comorbid physical and emotional illnesses (Piszkda, 2009). Racially and ethnically diverse adolescents may encounter more developmental challenges and complex health needs, all of which compromise their biopsychosocial health, and thus, intensify their health care inequities (DHHS, 2001).

Urologic disorders add another cultural layer for consideration in providing adolescent health care. Urologic problems produce degrees of biological change, alter physiologic functions, and intensify mental distress in the adolescent as well as the family and significant others in the adolescent's life (Sweeney, Marie, Kim, & Ferrer, 2008; Sweeney, Rzepski et al., 2008). Treatment approaches often increase stress in the lives of adolescents because they are physically intrusive and may be uncomfortable. It is important that clinicians who manage and/or provide care for these adolescents recognize normal adolescent developmental stages, alterations from these stages, and mental distress symptoms.

**Rating Checklists to Screen For Mental Distress**

As previously mentioned, adolescence is a time of identity and role confusion for teens. Mood changes, stress, and anxiety are often part of the normal adolescent experience. Nurses can facilitate the development of positive coping strategies and good health care behaviors. Nurses specializing in the care of adolescents with urologic problems often have long-term care relationships with their patients. It is imperative for these nurses to recognize symptoms indicative of mental distress that could progress into mental illness. This section will focus on the use of appropriate checklists urologic nurses can use in their practice settings.

These checklists are easy to use and can provide important data for the urologic nurse to use in deciding whether additional mental health screening is required. Table 1 presents a summary of behavior checklists, which are appropriate for parents, teachers, adolescents, and non-mental health nurses to use. The symptom ratings determined through the administration of these checklists do not indicate a specific mental illness disorder. They are used to identify the possible presence of symptoms, such as anxiety, depression, hyperactivity, inattention, disordered thoughts, social skill problems, and psychosocial challenges, as well as disruptive behaviors (Sajatovic & Ramirez, 2003).

Results from these checklists can be summarized by the urologic nurse/clinician and provided in a collaborative referral process with health care providers (advanced practice psychiatric and mental health nurses, psychiatrists, psychologists, and social workers) who specialize in the biopsychosocial psychiatric care of adolescents. The American Psychiatric Nurses Association (APNA) can provide names of psychiatric nurses at state and national levels, and the local chapter of the Mental Health Association (MHA) is another resource for referral availability of other mental health specialists. Another resource for mental health information on adolescents is available through the Substance Abuse & Mental Health Services Administration (SAMSA) (http://www.samhsa.gov). Pamphlets and other written information are available through SAMHSA for nurses/clinicians to share with adolescents, parents, guardians, or significant others.
Evidence-Based Culturally Competent Urologic Nursing Care

The World Health Organization has made recommendations regarding the provision of quality adolescent health care. According to these recommendations, care must be accessible, acceptable, appropriate, effective, and equitable (National Academies of Science, National Research Council, 2008). These recommendations mirror culturally competent recommendations from the Office of the Surgeon General and other experts in the field of cultural research, and they emphasize the need to incorporate all adolescent cultural layers. The Committee on Adolescent Health Care Services and Models of Care for Treatment has made a recommendation particularly relevant to the nursing care of adolescents diagnosed with comorbid disorders:

Providers of adolescents need to include disease prevention, health promotion, and behavioral health – including early identification, management, and monitoring of current or emerging health conditions and risky behavior – a major component of routine health services (National Academies of Science, National Research Council, 2008).

Adolescents express symptoms of emotional distress in different ways than adults. For example, they may use unique words and sayings that reflect their adolescent cultural experience. Family members and/or significant others have influenced the adolescent’s cultural beliefs, values, and norms, which are based on his or her upbringing. Hence, those cultural perspectives/layers of culture (such as developmental stage, age, mental and physical health status, race, ethnicity, religion, sexual orientation, biologic sex, group and/or community attachments, and environmental settings) guide thought processes and interactions with nurses and other health care providers (Warren, 2008b). Nurses’ use of therapeutic communication is an important culturally competent communication technique intended to address behaviors related to potential adolescent emotional lability (Deering & Scalll, 2008). Case study exemplars demonstrate how culturally competent nursing care might be structured (see Figure 1).

Summary and Conclusions

Untreated mental disorders create a variety of problems for adolescents experiencing urologic problems. Depression is one of the most common mental health disorders that can affect adolescent well being. Eight out of 100 adolescents may be affected by depression (DHHS, 1999). Anxiety disorder may also have roots in the depressive symptoms that begin in adolescence (DHHS, 1999). The presence of persistent sadness, anxiety, concentration challenges, increased fear and the development of phobias, intense irritability, lack of self-esteem, sleep alterations, and self-harm symptoms cause major disruptions in an adolescent’s life (APA,

<table>
<thead>
<tr>
<th>Name: Purpose</th>
<th>Age in Years</th>
<th>User/Rater</th>
<th>Completion Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Behavior Checklist: Rate presence of possible anxiety, depression, disordered thoughts</td>
<td>6 to 18</td>
<td>Parent, teacher, adolescent, nurse</td>
<td>15 to 20 minutes for each user to complete his or her section</td>
</tr>
<tr>
<td>Behavior Assessment System for Children: Rate adaptability, activities of daily living, social skills levels</td>
<td>2 to 21</td>
<td>Parent, teacher, adolescent, nurse</td>
<td>10 to 30 minutes for each user to complete his or her section</td>
</tr>
<tr>
<td>Child/Adolescent Psychiatry Screen: Rate and prioritize presence of any mental distress symptoms</td>
<td>3 to 21</td>
<td>Parent, nurse</td>
<td>15 to 20 minutes</td>
</tr>
<tr>
<td>Connors 3: Rate presence of possible conduct and learning problems, anxiety, hyperactivity, impulsive behaviors</td>
<td>3 to 17</td>
<td>Parent, teacher, nurse</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Pediatric Symptom Checklist: Rate level of functioning regarding possible psychosocial problems</td>
<td>6 to 16</td>
<td>Parent, nurse</td>
<td>5 to 10 minutes</td>
</tr>
<tr>
<td>SNAP-IV-C Rating Scale – Revised: Rate presence of possible hyperactivity, inattention symptoms</td>
<td>6 to 18</td>
<td>Parent, teacher, nurse</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Beck Youth Inventories of Emotional and Social Impairment: Rate adolescent’s self-esteem level and experience regarding possible depression, anxiety, anger, disruptive behaviors</td>
<td>7 to 14</td>
<td>Adolescent</td>
<td>25 to 35 minutes</td>
</tr>
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Case Study #1: Depression

Kyle is a 13-year-old male who presents in the urologic clinic with a complaint of intermittent testicular pain. Kyle is of mixed race; his father is Asian, and his mother is Caucasian. Kyle weighs 80 pounds and is 5 foot 1 inch in height. He makes minimal eye contact and keeps his arms folded over his chest. His voice is very soft and barely audible. The nurse enters the examination room, and the following conversation ensues:

Nurse: “I need to ask you some questions. I want you to answer me as best you can. I will share what you tell me with the doctor, and then he may ask you more questions. This is how we find out how to help you. Okay?”

Kyle: (looks at his hands, then his mother). This interchange indicates a level of anxiety in Kyle as he is looking away and is speaking in a very soft voice.

Nurse: “Tell me, in your own words, why you are here.”

Kyle: “Well, mostly because she (points to his mother) made me come.”

Nurse: “And why do you think she made you come to the clinic today?”

Kyle: “I guess because she’s worried about the pain.”

Mother: “Yes, I am very worried. He doubled over in pain yesterday, and they sent him home from school.”

Kyle: (looks anxiously at his hands, which are trembling slightly, and turns them over and over)

Nurse: “Kyle, tell me about your pain. Where does it hurt, and what does it feel like? When does it happen? What are you doing when it happens, and how long does it last? Is there anything that makes it better or worse?”

Kyle: “I start to hurt in my stomach, and sometimes, I feel like throwing up. It’s really hard to walk when I hurt. I am very sore. Nothing helps. It lasts for awhile and then goes away.”

Nurse: “Where are you sore?”

Kyle: (blushes and points to his scrotal area) “Here.”

Nurse: “Okay, is there anything else you can tell me?”

Kyle: (quickly looks at his mother and shakes his head to indicate no)

The nurse asks Kyle’s mother to go back to the waiting area, explaining that she may return after the examination. During the examination, Kyle shamefully shares that he has few friends, kids at school tease him and call him names, and he would rather stay home in his room where he feels safe. Kyle is assured that his pain is not related to masturbation, that many boys and men masturbate, and that masturbation is not abnormal. On physical examination, Kyle has a high-riding right testicle, diffuse tenderness with a normal cremasteric reflex. Additional studies are ordered, and all results are normal. The diagnosis of intermittent testicular torsion is made, with a recommendation of elective testicular fixation in the near future (Mayo Clinic, 2009).

After the physical examination, the nurse talks with Kyle briefly about his problems at school. Kyle describes an environment of being ridiculed for being small. He also says that because he does not like sports, the other kids sometimes call him a sissy. Kyle shares that he does not like school and prefers to be alone. He adds that when he has to go to school, he often feels shaky, nauseated, and afraid. Kyle admits he does not know why he feels “sick” when he has to leave his home and especially his room. The nurse probes further and asks if he feels sad. He replies, “Being sad is normal for me.” The nurse asks Kyle if he would be willing to complete a questionnaire that could help him get treatment so he will not always feel sad and anxious. He agrees, and the Mini-Mental State Examination (MMS E) is completed. Based on Kyle’s answers, all indications are that he needs further evaluation and treatment for depression and social anxiety disorder. The urology clinician and nurse talk with Kyle and his mother, who both agree to see a mental health professional. A referral is made to a psychiatric clinician specializing in adolescents. Kyle’s mother voices concern that he could be hurt by psychiatric treatment and he will be labeled as crazy. After further discussion about the risks and benefits of counseling, an appointment is scheduled. A date is set for elective surgical fixation of the right testicle in conjunction with further evaluation and therapeutic treatment for depression.

When Kyle returns two months later for his post-operative visit, he is more talkative, has an improved level of energy, smiles easily, and makes eye contact. Kyle’s mother states she is happy with how much better he feels. She comments, “Kyle has learned that he is a good person and that he needs help with his depression and social anxiety.” She also notes that Kyle has made some friends who he now feels comfortable visiting and calling.

Nurses are in a unique position to provide leadership in the care of adolescent populations. The initial behavior and appearance of the patient often prompt pre-judgment. Kyle presents as a very quiet, soft-spoken young man, and if preconceived ideas or biases are permitted to intrude, he may be perceived as effeminate. Instead, the nurse asks probing questions and gathers information relevant to the chief complaint. It is not unusual for adolescents to feel shame for sexual feelings and to associate health issues with doing something “bad,” such as masturbation. Parents may also contribute to this belief in their attempts to control behavior. Recognition of opportunities to educate parents and adolescents are essential for nurses/clinicians.

Referring Kyle and his mother for psychiatric counseling was important in meeting the needs of this family. Consultation, appropriate therapeutic interventions, and collaboration among professionals are vital in insuring the best professional care for patients and families.

Case Study #2: Eating Disorders

Leah is a 17-year-old African-American female with a history of depression following the loss of her grandmother two years ago. Leah developed a dull backache two days ago, which has increased in severity. Her mother wanted to take Leah to the emergency room, but she refused saying, “The last time I went there because I felt so weak and tired, all they did was tell me I need to see a nut doctor.” The back pain has prevented her from going to school for the past two days, and now her urine is light pink. Leah’s mother has finally convinced her to get medical attention for the worsening back pain, and
LEAH, A 22-YEAR-OLDB CAUCASIAN MALE, WAS ADMITTED TO THE LOCAL HOSPITAL FOR DEPRESSION SECONDARY TO METHAMPHETAMINE ABUSE. HIS PARENTS REPORT THAT HE WAS TREATED FOR DRUG USE IN THE PAST, BUT ON THIS ADMISSION, THEIR PRIMARY CONCERN WAS HIS CONFUSED SPEECH, HIS NONSENSE STATEMENTS, AND SEEING BLOOD ON HIS PANTS, THE SHEETS, AND THE BATHROOM FLOOR. UPON ADMISSION, MENTAL HEALTH SERVICES REQUESTED A UROLOGIC CONSULT FOR GROSS HEMATURIA.

DURING THE ASSESSMENT, SEVERAL QUESTIONS WERE ASKED ABOUT PAINFUL URINATION AND TRAUMA TO THE ABDOMEN, KIDNEYS, OR URINARY TRACT. JAMES’ RESPONSE IS RIDDLED WITH RHYMES AND STATEMENTS INDICATING THAT HIS URINE IS AN INDICATION OF HIS SPIRITUALITY AND A GIFT FROM THE RED RIVER VALLEY. DURING THE PHYSICAL ASSESSMENT, SMALL ABRASIONS AND BLEEDING WERE NOTED AT THE URETHRAL OPENING. SEVERAL DIAGNOSTIC TESTS, INCLUDING X-RAYS, WERE ORDERED. EVALUATION OF THE DIAGNOSTIC STUDIES INDICATED SEVERAL SMALL FOREIGN OBJECTS IN THE URETHRA. WHEN QUESTIONED ABOUT HOW THE OBJECTS GOT INTO THE URETHRA, JAMES STATED HE DID NOT KNOW, BUT THE RED RIVER VALLEY PEOPLE KNEW.

AFER A CONSULTATION WITH HIS PSYCHIATRIST, HE WAS DEEMED STABLE ENOUGH TO UNDERGO REMOVAL OF THE FOREIGN ITEMS IN HIS URETHRA UNDER GENERAL ANESTHESIA. FOLLOWING SURGERY, JAMES WAS PLACED IN AN OBSERVATION ROOM, AND ALL ITEMS THAT HAD ANY PROBABILITY OF BEING INSERTED INTO THE URETHRA WERE REMOVED FROM THE ROOM. HIS MENTAL HEALTH AND UROLOGIC TEAM COLLABORATED TO DEVELOP A PLAN OF CARE THAT INCLUDED MEDICATION TO STABILIZE HIS SCHIZOPHRENIA, FAMILY COUNSELING, AND CONTINUOUS EVALUATION OF HIS UROLOGIC FUNCTION. UPON DISCHARGE, JAMES WAS CALM, HIS THOUGHTS WERE CLEAR, AND HE WAS ABLE TO CONVERSE EASILY WITH OTHERS. UROLOGIC FOLLOW-UP SEVEN DAYS POST-DISCHARGE WAS NEGATIVE FOR HEMATURIA. MENTAL HEALTH CARE WAS ONGOING.

IT IS NEVER EASY TO ACCEPT OR ADMIT THAT A FAMILY MEMBER HAS MENTAL HEALTH ISSUES. UNFORTUNATELY, STIGMA IS STILL ASSOCIATED WITH MENTAL HEALTH ALTERATIONS, SUCH AS SCHIZOPHRENIA. HOWEVER, MANY CARE PROVIDERS ACTIVELY SEEK TO UNDERSTAND AND HELP RATHER THAN ISOLATE AND IGNORE PATIENTS AND FAMILIES COPING WITH THIS DISEASE. IN THE PAST, PATIENTS LIKE JAMES WOULD BE INSTITUTIONALIZED. SCHIZOPHRENIA AND OTHER MENTAL HEALTH ISSUES CONTINUE TO BE THE FOCUS OF RESEARCH TO BETTER UNDERSTAND THE CONNECTION AMONG GENETICS, DRUG USE/ABUSE, OR ENVIRONMENTAL FACTORS. MENTALLY ILL PATIENTS WILL EXPERIENCE PHYSIOLOGICAL ILLNESS, AND THE FOCUS OF THE HEALTH CARE PROVIDER MUST BE ON HOMEOSTASIS. IN ALL CASES, TREATMENT IS NOT ONLY FOR THE PATIENT, BUT ALSO FOR THE FAMILY. THERAPY CAN ASSIST FAMILIES TO DEVELOP MORE EFFECTIVE COMMUNICATION AND SKILLS TO HELP MAINTAIN HEALTHIER LIFESTYLes AND BETTER UNDERSTAND THE NEEDS OF THE PERSON WITH MENTAL HEALTH ISSUES.
2009). In addition, fluctuations in the normal developmental stage during the adolescent years can exacerbate pre-existing psychiatric symptoms and alter the physiologic healing processes for the adolescent experiencing urologic problems. Depressive and anxiety symptoms are often comorbid with eating disorders and schizophrenia (APA, 2000).

Symptoms of mental health disorders often mirror normal adolescent developmental stage characteristics. However, symptoms of mental illness are more prolonged and higher in intensity than “normal” developmental fluctuations. They may be entirely out of character for the adolescent’s usual behavior. The connections between layers of culture and mental health are tied to issues that formulate quality nursing care of adolescents 13 to 23 years of age who are experiencing urologic problems.

Urologic nurses/clinicians are in a unique position to identify symptoms of mental distress in adolescents. Collaboration with psychiatric/mental health professionals can be an important component in the care and treatment of adolescents with urologic problems. Culturally competent care, which involves skills in identifying cultural factors important to adolescents and their families, greatly increases the possibility of successful outcomes.

References


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Additional Reading