This is the first of two special issues focusing on adjunctive treatments for psychiatric clients. In this introduction to the first special issue, I wish to highlight several points about the term *adjunct*. Synonyms for the word *adjunct* include *appendage, attachment,* and *addition*. Thus, one might surmise that adjunctive treatments are provided in addition to standard treatment offerings. Therein lies the difficulty, for this implies that there is some agreed-on “standard” treatment. While expert consensus treatment guidelines are available for most disorders, in the United States, many people with a variety of mental health diagnoses (depression comes to mind) receive no treatment at all. In other cases, “standard” treatment is defined neither by guidelines nor client need, but by location, economics, level of clinician expertise, and/or other factors.

In the mind of a clinician, family member, or client, the term *adjunct* may imply lesser status than other treatments, giving the impression that a less robust response is expected or that less evidence for efficacy exists. In fact, the opposite may be true. As the articles in this issue indicate, response rates are such that many so-called...
“adjunctive” treatments deserve consideration alongside first-line offerings. Clinicians can help clarify these matters, one client at a time. Clinicians and clients must choose treatments together, using the best available evidence and taking into account individual client variability.

Finally, misconceptions about status among treatments or limited evidence of efficacy might lead clinicians, clients, and most importantly, payors, to conclude that adjunct treatments are nonessential. Our research colleagues have work to do on this front. More experimental research with larger samples is needed to demonstrate the results of adjunctive treatments in different client groups to build the case for the cost effectiveness of their coverage.

This special issue highlights a number of little-used psychiatric treatments with considerable evidence of efficacy and acceptability across age ranges and diagnostic categories. Masini explores equine-assisted psychotherapy in clinical practice, and Weber reNews evidence supporting the use of exercise interventions in people with chronic mental illnesses. Mottern concludes that hypnosis is underused in psychiatric nursing, given its documented efficacy for stress reduction and sleep pattern improvement. Finally, in the most universally applicable discussion, Crocker defines mental health in relationship to ecological and environmental patterns and calls, as did Nightingale, for an examination of the nutritional patterns of clients and nurses alike.

What are the barriers to incorporating exercise, nutrition, and other interventions into practice? Practitioner-related barriers include lack of knowledge, lack of time, or concerns about quality of evidence. Patient-related barriers such as symptoms or adherence challenges are also an issue. And we cannot discount system-related barriers such as lack of support for innovation in treatment settings. I challenge each of us, as psychiatric nurses, to begin addressing these barriers today, starting with our own attitudes and preconceptions. If we are to provide holistic care, we cannot concern ourselves solely with the psychiatric aspects of health; rather, we must be prepared to explore any safe treatment to enhance overall health and quality of life.

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The author discloses that she has no significant financial interests in any product or class of products discussed directly or indirectly in this activity, including research support.

doi:10.3928/02793695-20100831-06