The Therapeutic Nurse-Patient Relationship
In a therapeutic relationship...

- There are specific goals
- The patient’s needs are the focus (relationship is client centered)
- The nurse makes use of specific communication and relationship skills
In a social relationship...

- There are not necessarily specific goals beyond friendship and socializing
- The needs of both parties are the foci
- The information exchanged may remain superficial
- The skills used are the general socialization and communications skills everyone in the culture uses
In an intimate relationship...

- Mutual needs are met
- Each party usually cares about meeting the needs of the other
- The parties have an emotional commitment to each other
- Mutual fantasies and desires may be satisfied
- Information shared may be personal and intimate
Therapeutic use of self:

- Ability to use one’s personality consciously and in full awareness in an attempt to establish relatedness and to structure nursing interventions

Therapeutic communication:

- Consists of verbal and nonverbal techniques that focus on the client’s needs and advance the promotion of healing and change
- Encourages the exploration of feelings and fosters understanding of behavioral motivation
- Promotes trust, discourages defensiveness, and is nonjudgmental
Conditions essential to the development of a therapeutic relationship include:

- **Rapport**
  - special feelings on the part of both the client and nurse based on acceptance, warmth, friendliness, common interest, a sense of trust, and a nonjudgmental attitude
  - establishing rapport may be accomplished by discussing non-health-related topics

- **Genuineness**
  - the ability to be open, honest, and “real” in interactions
Trust
- confidence in another person’s presence, reliability, integrity, veracity, and sincere desire to provide assistance when requested
  - providing a blanket when the client is cold
  - providing food when the client is hungry
  - keeping promises
  - being consistent
  - ensuring confidentiality
(cont’d)

- **Respect**
  - unconditional positive regard
    - calling the client by name
    - spending time with the client
    - allowing sufficient time to answer the client’s questions or concerns
    - always being open and honest
    - striving to understand the motivation behind the client’s behavior

- **Empathy**
  - process in which one is able to see beyond outward behavior and accurately sense another’s inner experience
Boundary issues within a professional relationship may include:

- **Transference**
  - When the client unconsciously attributes to the nurse feelings and behavioral dispositions formed toward a person from his or her past

- **Countertransference**
  - The nurse’s behavioral and emotional response to the client which may be related to unresolved feelings toward significant others from the nurse’s past, or may be generated in response to transference feelings on the part of the client
Self-disclosure
- May be appropriate when the information to be shared is judged to be therapeutically beneficial to the client
- Never used for the purpose of meeting the nurse’s own needs

Gift-giving
- Professional judgment
- Institutional policy
- Never financial
  - suggest a donation elsewhere
Boundary issues (cont’d)

- Touch
  - Caring touch with no associated physical need can be therapeutically appropriate
  - Beware of situations in which touch may be misinterpreted, culturally unacceptable, or dangerous
    - paranoid patient
    - psychotic client
Warning signs that may indicate a potential breech in professional boundaries in the nurse-client relationship include:

- Favoring one client’s care over another’s
- Swapping assignments with another nurse to care for a particular client
- Giving special attention or treatment to one client over others
- Spending free time with one particular client
- Sharing personal information or work concerns with a client
- Continuing contact/communication with a client after discharge
Phases of a Therapeutic Relationship

- Preorientation or preinteraction phase
- Orientation phase
- Working phase
- Termination phase
Preinteraction Stage

- Self-exploration
- Create the setting – comfortable, safe
- Prepare for the interaction/relationship – review patient’s history, diagnosis, review nursing theory
- Anticipate obstacles, difficulties
- Consider the timing of nurse/patient interactions
Orientation or Introductory Stage

- Introductions
- Discuss nurse’s role
- Gives patient information about the purpose, possible goals, and the time frame of the relationship
- Include the patient as a partner in the relationship
Assess the patient’s problems and needs
Plan goals and outcomes with the patient
Develop trust and rapport with the patient
Demonstrate caring
Demonstrate that you see the patient as an individual
Working Stage

- Implement the plan of care
- Evaluate intermediate outcomes
- Re-plan if necessary; think of alternative solutions
- Implement alternative solutions
- Refer patient, if necessary
Termination Stage

- Begins during the first interaction with the patient
- Occurs when goals have been reached or referral is advisable
- Nurse and patient examine meaning and value of the relationship
- Feelings are discussed
Termination Stage cont.

- Plans for follow-up are made, if necessary
- Anticipatory guidance and/or teaching should be done or repeated
- Evaluation of outcomes
- Summarization of the relationship and the goals achieved
- Give this stage adequate time but do not dwell on it
Boundaries

- Psychological, communication
  - Be aware of the nurse’s role
  - Limit self-disclosure
  - Be aware of over involvement
  - Confront/correct sexual innuendos or actions
Boundaries cont.

- Physical
  - Allow the patient his/her personal space
  - Use touch cautiously
  - Be aware of patient’s cultural pattern
Transference

- Transference – “…a person unconsciously and inappropriately displaces onto individuals in his or her current life those patterns of behavior and emotional reactions that originated with significant figures in childhood.” (Varcarolis, 1998)
Countertransference

- Countertransference – “…the tendency of the therapist to displace onto the client feelings caused by people in the therapist’s past.” (Varcarolis, 1998)
Countertransference cont.

- Dealt with best by self-examination and by supervision by a more experienced professional or by a peer.
Different between social and professional relationship:

<table>
<thead>
<tr>
<th><strong>Professional relationship</strong></th>
<th><strong>Social relationship</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Concerned with helping the patients (regardless their sex, religion, race...etc.)</td>
<td>Interaction is primarily for reason of pleasure or companion-ship.</td>
</tr>
<tr>
<td>Require the help of person with scientific knowledge and special skills (the nurse).</td>
<td>No person is in the position of responsibility of helping the other.</td>
</tr>
<tr>
<td>There is intention of dealing with other's problem.</td>
<td>There is no this intention.</td>
</tr>
<tr>
<td>The relationship is purposeful directed toward a therapeutic.</td>
<td>The goal is more or less social</td>
</tr>
<tr>
<td>The relationship should not entail the nurse's personal matters or problems.</td>
<td>It is up to the partners to share their personal affairs.</td>
</tr>
<tr>
<td>Time limited.</td>
<td>Unlimited.</td>
</tr>
</tbody>
</table>
INTERPERSONAL COMMUNICATION

- is a transaction between the sender and the receiver.
- In the transactional model of communication, both participants are simultaneously:
  - perceiving each other,
  - listening to each other,
  - and mutually involved in creating meaning in a relationship
The Impact of Pre-existing Conditions

In all interpersonal transactions, both the sender and receiver bring certain pre-existing conditions to the exchange that influence both the intended message and the way in which it is interpreted.
Factors that may influence the outcome of the transaction

- value system, internalized attitudes and beliefs.
- culture or religion
- social status (SES)
- Gender
- background knowledge and experience
- age or developmental level.
- The type of environment in which the communication takes place.
Territoriality, density, and distance

- **Intimate distance** is the closest distance that individuals will allow between themselves and others (0-18 inch).
- **Personal distance** is approximately 18 to 40 inches and is reserved for interactions that are personal in nature, such as close conversations with friends or colleagues.
- **Social distance** is about 4 to 12 feet away from the body. Interactions at this distance include conversations with strangers.
- **Public distance** is one that exceeds 12 feet.
Nonverbal
Verbal Communication
- The words we use

Nonverbal Communication
- Bodily actions and vocal qualities that typically accompany a verbal message
Characteristics of Nonverbal Communication

- Intentional or unintentional
- Ambiguous
- Primary
- Continuous
- Multichanneled
Functions of Nonverbal Communication

- To provide information
- To regulate interaction
- To express or hide emotion and affect
- To present an image
- To express power and control
Regulate Interaction

Facial expressions or gestures that are used to control or regulate the flow of a conversation
Express Emotion or Affect

- Facial expressions and gestures that augment the verbal expression of feelings
Types of Nonverbal Communication

- Kinesics
- Paralanguage
- Vocal interferences
- Spatial Usage
- Self-presentation cues

Everything but the words!
Kinesics

- Eye Contact
- Facial expressions
- Emoticons
- Gesture
- Posture
- Touch
Touching and being touched are essential to a healthy life. Touch can communicate power, empathy, understanding.
Paralanguage

- Pitch
- Volume
- Rate
- Quality
- Intonation
Vocal Interferences

- Extraneous sounds or words that interrupt fluent speech
  - “uh,” “um”
  - “you know,” “like”
- Place markers
- Filler
Spatial Usage

- Proxemics
  - Intimate distance
  - Personal distance
  - Social distance
  - Public Distance
- Territory
Personal Space at Work

- Your office
- Your desk
- A table in the cafeteria that you sit at regularly
Color Influences Communication

Yellow cheers and elevates moods
Red excites and stimulates
Blue comforts and soothes

In some cultures, black suggests mourning
In some cultures, white suggests purity
Self-Presentation Cues

- Physical Appearance
- Time
- Olfactory Communication
Self-Presentation

- What message do you wish to send with your choice of clothing and personal grooming?
Time

- How do we manage and react to others’ management of time
  - duration
  - activity
  - punctuality
Cultural and Gender Variations
Nonverbal Signals

Vary from culture to culture
What does this symbol mean to you?

- In the United States it is a symbol for good job
- In Germany the number one
- In Japan the number five
- In Ghana an insult
- In Malaysia the thumb is used to point rather than a finger
Improving Nonverbal Communication Skills

• When sending messages
  • Be conscious of nonverbal behavior
  • Be purposeful in use of nonverbals
  • Make sure nonverbals are not distracting
  • Match verbal and nonverbal communication
  • Adapt to the situation
Improving Nonverbal Communication Skills

- When receiving messages
  - Don’t automatically assume
  - Consider gender, culture and individual differences
  - Pay attention to all aspects of nonverbal communication
  - Use perception checking
Therapeutic Communication Techniques (table 6-3 p.107)

- Active listening
  - Expression of interest
  - Leaning forward
  - Nodding head
  - Verbalizations such as “Uh-huh” and “Go on…”
- Frequent validation
- Attempt to fully understand
Silence

- If you don’t know what to say, say nothing
- Gives patient time to think
- Gives nurse time to think
- May allow patient to expand upon what he was saying or think of a new topic to discuss
- As anxiety grows, patient is more likely to say something
Exploring

- Trying to get the patient to expand upon a topic or bring up another topic
- “Would you tell me more about that?”
- “What else makes you feel that way?”
Restating

Pt.: “I couldn’t sleep all night.”
Nurse:”You couldn’t sleep all night.” or “You couldn’t sleep all night?”
Pt.: “My husband is very worried about me.”
Nurse:”Your husband is very worried about you.” “Your husband is very worried about you?”
Theme Identification

“I’ve noticed that in all of the relationships that you have described, you’ve been hurt or rejected by the man. Do you think this is an underlying issue?”
Paraphrasing
- Repeating what the patient says in different words
  - Pt.: “I’m worried about my operation tomorrow.”
  - Nurse: “You’re concerned about tomorrow’s surgery.” (or ?)
Suggesting

“Have you thought about responding to your boss in a different way when he raises that issue with you?”
Reflecting or validating
- signifies understanding, empathy, interest, and respect for the patient. It consists of repeating in fewer and different words the essential ideas of the patient. (similar to paraphrasing) Reflection can refer to content or feelings.
Open-ended questions
“Tell me what happened?”
“How are you today?”
Focusing –

“Can we continue talking about your mother right now?”
Clarifying, validating

“I’m having some difficulty. Could you help me understand?”
Humor

“That gives whole new meaning to the word nervous,” (said with shared kidding between the nurse and the patient).
Summarizing

"So far we have talked about.."
Informing

“I think you need to know more about how your medication works.”
Non-therapeutic Communication (table 6-4 p.110)

- False Reassurance
  - “Everything’s going to be all right.”
  - “You’re doing just fine.”
  - Pt.: “I’m afraid I won’t wake up from the surgery.”
  - Nurse:”Sure you will.”
Barriers cont.

- Giving approval or disapproval; being judgmental; agreeing or disagreeing
  - “I wouldn’t say that.”
  - “Of course; I agree.”
Barriers cont.

- Giving advice
  - “If I were you...”
  - “I think you should...”
  - “It seems to me the best course of action is...”
Barriers cont.

- Defending
  - Pt.: “The nurses were very slow answering my light last night.”
  - Nurse: “I don’t know how you can say that. This floor has the best nurses in the hospital.”
Barriers cont.

- Minimizing feelings
  - Pt.: “I’m quite scared about this surgery.”
  - Nurse:”Oh, everyone feels that way before an operation.”
  - Pt.: ”I really hate shots.”
  - Nurse.”Don’t be silly. It’s just a little stick.”
Barriers cont.

- Changing the subject
  - Pt.: “I hope someone comes to visit me today.”
  - Nurse: “It’s such a beautiful day today.”
Social response
- nurse uses superficial social conversation that is not client-centered.
- “How does the coffee taste today?”
The Nursing Process in Psychiatric/Mental Health Nursing
Assessment and Documentation

- Key to contributing to establishment of psychiatric diagnosis
- Proper diagnosis leads to effective treatment
- Nursing input is more crucial in the diagnostic process in psychiatry than medical and surgical settings
Medical-Surgical Diagnosis

- MD physical exam
- Tests such as EKG and X-ray
- Labs – blood and body fluid analysis
- RN assessment minor in diagnosis
- RN use of the nursing process to enhance med-surg treatment via nursing interventions/nursing process
Psychiatric Diagnosis

- MD physical exam to rule out medical conditions
- Mental status exam (MSE) by MD and Nursing
  - observations of patient behavior in the environment over time
  - interactions with patient over time
- Some labs
- Some psychological tests if needed for Differential Diagnosis
- Establishes diagnosis and yields most effective treatment
Nursing Observation and Documentation

- Nurses do parts or all of the MSE
- Nurses observe patient behavior and interactions
- Nurses document response to treatment
- MD re-interview also establishes response to treatment
- Nurses also use nursing process to provide independent care
- Psychiatric DX and care is multidisciplinary
Holistic - Biopsychosocial

- Hx of present illness, Psychiatric Hx, Substance use Hx, Coping skills – PSYCHOLOGICAL
- Medical Hx – PHYSICAL
- Family Hx and Developmental Hx – PSYCHOLOGICAL, PHYSICAL, SOCIAL
- Social, Occupational/Educational Hx, Culture – SOCIAL
- Spirituality - SPIRITUAL
The psychiatric-mental health nurse utilizes the nursing assessment tools:

- to obtain factual information
- observe appearance and behavior
- evaluate the patient’s mental or cognitive status.
APPEARANCE

General appearance includes: **physical characteristics, apparent age, peculiarity of dress, cleanliness, and use of cosmetic**.

- A person's general appearance, including facial expressions, is a manner of nonverbal communication in which emotions, feelings, and mood are related.
- For example, depressed people often neglect their personal appearance, appear disheveled, and wear drab-looking clothes that are generally dark in color, reflecting a depressed mood.
- The facial expression may appear sad, worried, tense, frightened, or distraught.
- Manic patients may dress in bizarre or overly colorful outfits, wear heavy layers of cosmetics, and several pieces of jewelry.
BEHAVIOR, ATTITUDE, AND NORMAL COPING PATTERNS:

The interviewer assesses patients’ actions or behavior by considering the following factors:

1. Do they exhibit strange, threatening, or violent behavior? Are they making an effort to control their emotions?

2. Is there evidence of any unusual mannerisms or motor activity, such as grimacing, tremors, tics, impaired gait, psychomotor retardation, agitation? Do they pace excessively?

3. Do they appear friendly, embarrassed, evasive, fearful, resentful, angry, negativistic, or impulsive? Their attitude toward the interviewer or helping persons can facilitate or impair the assessment process.

4. Is behavior overactive or underactive? Is it purposeful, disorganized, or stereotyped? Are reactions fairly consistent?
PERSONALITY STYLE AND COMMUNICATION ABILITY

“The manner in which the patient talks enables us to appreciate difficulties with his thought processes. It is desirable to obtain a verbatim sample of the stream of speech to illustrate psychopathologic disturbances” (Small, 1980, p. 8).
Factors to be considered while one is assessing patients’ ability to communicate and interact socially include the following:

1. Do they speak coherently? Does the flow of speech seem natural or logical, or is it illogical, vague, and loosely organized? Do they enunciate clearly?

2. Is the rate of speech slow, retarded, or rapid? Do they fail to speak at all or respond only when questioned?

3. Do patient whisper or speak softly, or do they speak loudly or shout?

4. Is there a delay in answer or responses, or do patients break off their conversation in the middle of a sentence and refuse to talk further?

5. Do they repeat certain words and phrases over and over?

6. Do they make up new words that have no meaning to others?

7. Is their language obscene?

8. Does their conversation jump from one topic to another?

9. Do they stutter, lisp, or regress in their speech?

10. Do they exhibit any unusual personality traits or characteristics that may interfere with their ability to socialize with others or adapt to hospitalization?
   - For example, do they associate freely with other or do they consider themselves “loners”? Do they appear aggressive or domineering during the interview?
   - Do they feel that people like them or reject them? How do they spend their personal time?
The following terminologies are generally used to describe impaired communication observed during the assessment process:

1. BLOCKING
2. CIRCUMSTANTIALITY
3. FLIGHT OF IDEAS
4. PERSEVERATION
5. VERBIGERATION
6. NEOLOGISM
7. MUTISM
BLOCKING

This impairment is a sudden stoppage in the spontaneous flow or stream of thinking or speaking for no apparent external or environmental reason.

Blocking may be due to preoccupation, delusional thoughts, or hallucinations; for example, while talking to the nurse, a patient stated, “My favorite restaurant is Chi-Chi’s. I like it because the atmosphere is so nice and the food is . . .” Most often found in schizophrenics during audio hallucinations.
CIRCUMSTANTIALITY

In this pattern of speech the person gives much unnecessary details that delays meeting a goal or stating a point. For example, when asked to state his occupation, a patient gave a very detailed description of the type of work he did. Commonly found in manic disorder and some organic mental disorders.
FLIGHT OF IDEAS
This impairment is characterized by over productivity of talk and verbal skipping from one idea to another. The ideas are fragmentary, although talk is continuous. Connections between the part of speech often are determined by change of associations; for example: “I like the color blue. Do you ever feel blue? Feelings can change from the day to day. The days are getting longer.” Most commonly observed in manic disorders.
PERSEVERATION
Perseveration is the persistent, repetitive expression of a single idea in response to various questions. Found in some organic mental disorders and catatonia.

VERBIGERATION
This term describes meaningless repetition of incoherent words or sentences. Observed in certain psychotic reactions and mental disorders.

NEOLOGISM
A neologism is a new word or combination of several words coined or self-invented by a person and not readily understood by others; for examples: “His phenologs are in the dryer.” Found in certain schizophrenic disorders.
MUTISM

This impairment is refusal to speak even though the person may give indications or being aware of the environment. Mutism may occur from conscious or unconscious reason. Observed in catatonic schizophrenic disorders, profound depressive disorders, and stupors of organic or psychogenic origin.

Other terminology such as loose association, echolalia, and clang association is described in the chapter discussing schizophrenic disorders.
EMOTIONAL STATE OR AFFECT:

**Affect** is defined as “the outward manifestation of a person’s feelings, tones, or mood.

Affects and emotion are commonly used interchangeably” (American psychiatric association, 1980, p. 3).

“The relationship between mood and the content of thought is of particular significance.

There may be a wide divergence between what the patient says or does on the one hand and his emotional state as expressed objectively in his face or attitudes.” (Small 1980, p. 10).

A lead question such as “**What are you feeling?**” may elicit such responses as “nervous,” “angry,” “frustrated,” “depressed,” or “confused.”

The person should be asked to describe the nervousness, frustration, or confusion. Is the person’s emotional response constant or does it fluctuates during the assessment?

The interviewer should record a verbatim reply to question concerning the patient’s mood and note whether an intense emotional response accompanies the discussion of specific topics.

Affective responses may be **appropriate, inappropriate, flat or blunted**. An emotional response out of proportion to a situation is considered inappropriate.
The American psychiatric association defines thought disorder as “a disturbance of speech, communication, or content of thought, such as delusions, ideas of reference. . . .

A thought disorder can be caused by a functional emotional disorder or an organic condition” (1980, p. 131).

Small (1980) and Rowe (1989) describe those thought contents more commonly exhibited during the psychiatric examination:

1. Delusions
2. Hallucinations
3. Depersonalization
4. Obsessions
5. Compulsions.
DELUSION:
A delusion is a fixed false belief not true to fact and not ordinary accepted by other members of the person’s culture.

It cannot be corrected by an appeal to the reason of the person experiencing it.

Delusions occur in various types of psychotic disorders, such as organic mental disorder and schizophrenic disorder, and in some affective disorders.
<table>
<thead>
<tr>
<th>TYPES OF DELUSIONS</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delusion of reference or persecution</td>
<td>One believes that he or she is the object of environmental attention or is being singled out for harassment. “The police are watching my every move. They’re out to get me.”</td>
</tr>
<tr>
<td>Delusions of alien control</td>
<td>The person believes his or her feelings, thoughts, impulses, or actions are controlled by an external source. “A spaceman sends me to do”.</td>
</tr>
<tr>
<td>Nihilistic delusions</td>
<td>The person denies the reality or existence of self, part of the self, or some external object. “I have no head”.</td>
</tr>
<tr>
<td>Delusion of self-deprecation</td>
<td>The individual feels unworthy, ugly, or sinful. “I don’t deserve to live. I’m so unworthy of your love.”</td>
</tr>
<tr>
<td>Delusion of grandeur</td>
<td>A person experiences exaggerated ideas of her or his importance or identify. “I am Napoleon!”</td>
</tr>
<tr>
<td>Somatic delusions</td>
<td>The person entertains false beliefs pertaining to body image or body function. The person actually believes that she or he has cancer, leprosy, or some other terminal illness.</td>
</tr>
</tbody>
</table>
Hallucinations are sensory perceptions that occur in the absence of an actual external stimulus.

They may be auditory, visual, olfactory, gustatory, or tactile in nature.

Hallucinations occur in substance-use disorders, schizophrenia, and manic disorders.
<table>
<thead>
<tr>
<th>Types of Hallucinations</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auditory hallucinations</td>
<td>Asie tells you that he hears voices frequently while he sits quietly in his long chair. He states, “The voices tell me when to eat, dress, and go to bed each night!”</td>
</tr>
<tr>
<td>Visual hallucinations</td>
<td>Ninety-years-old EK describes seeing spiders and snakes on the ceiling of his room late one evening as you make rounds.</td>
</tr>
<tr>
<td>Olfactory hallucinations</td>
<td>AJ, a 65-year-old psychotic patient, states that she smells “rotten garbage” in her bedroom, although there is no evidence of any foul-smelling material.</td>
</tr>
<tr>
<td>Gustatory (taste) hallucination</td>
<td>MY, a young patient with organic brain syndrome complains of a constant metallic taste in her mouth.</td>
</tr>
<tr>
<td>Tactile hallucinations</td>
<td>NX, a middle-aged woman undergoing symptoms of alcohol withdrawal and delirium tremens, complains of feeling “worms crawling all over (her) body.”</td>
</tr>
</tbody>
</table>
DEPERSONALIZATION:

Depersonalization is described as a feeling of unreality or strangeness concerning self, the environment, or both:
For example, patients have described out-of-body sensations in which they view themselves from a few feet overhead.

These people may feel they are “going crazy.”

Cause of depersonalization includes prolonged stress and psychological fatigue, as well as substance abuse. This feeling has been described in schizophrenia, bipolar disorders, and depersonalization disorders.
“Obsessions are insistent thoughts, recognized as arising from the self, usually regarded by the patient as absurd and relatively meaningless, yet they persist despite his endeavors to rid himself of them” (Small, 1980, p. 13).

Person who experience obsessions generally described their thoughts as “thoughts I can’t get rid of” or “I can’t stop thinking of things... they keep going on in my mind over and over again.”

Obsessions are typically seen in obsessive-compulsive disorders.
“An inconsistent, repetitive, intrusive and unwanted urge to perform an act contrary to one’s ordinary wishes or standards” (American psychiatric association, 1980, p. 21).

If one does not engage in the repetitive act due to an inner need or drive, one generally experiences feelings of tension and anxiety.

Compulsions are frequently seen in obsessive-compulsive disorders.
During the assessment, patients are asked questions regarding their ability to grasp the significance of their environment, an existing situation, or the clearness of conscious processes. In other words, are they oriented to person, place, time and events. Do they know who they are, where they are, or what the date is? Are they aware of the past and current events?

Levels of orientation and consciousness are subdivided as follows: confusion, clouding of consciousness, stupor, delirium, dream state, and coma.
<table>
<thead>
<tr>
<th>LEVEL</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confusion</td>
<td>Disorientation to person, place or time characterized by bewilderment and complexity.</td>
</tr>
<tr>
<td>Clouding of consciousness</td>
<td>Disturbance in perception or thought that is slight to moderate in degree, usually owing to physical or chemical factors producing functional impairment of the cerebrum.</td>
</tr>
<tr>
<td>Stupor</td>
<td>A state in which the person does not react to or is unaware of the surrounding. The person maybe motionless and mute but conscious.</td>
</tr>
<tr>
<td>Delirium or acute brain syndrome</td>
<td>Confusion accompanied by altered or fluctuating consciousness. Disturbance in emotion, thought, and perception is moderate to severe. Usually associated with infections, toxic states, head trauma, and so forth.</td>
</tr>
<tr>
<td>Dream state</td>
<td>Disturbed, clouded, or confused consciousness in which the person may not be aware to surroundings. Visual or auditory hallucinations may occur. May last several minutes to a few days</td>
</tr>
<tr>
<td>Coma</td>
<td>Loss of consciousness.</td>
</tr>
</tbody>
</table>
Memory, or the ability to recall past experiences, is divided into recent and long-term.

Recent memory is the ability to recall events in the immediate past and up to two weeks previously.

Long-term memory is the ability to recall remote past experience such as the date and place of birth, names of schools attended, occupational history and chronological data relating to previous illness.

Small (1980) states that memory defects maybe because of lack of attention, difficulty with retention, difficulty with recall, or any combination of these factors. Loss of recent memory maybe seen in patients which chronic organic brain dysfunction.
Three disorders of memory are:

- Hypermnesia or an abnormally pronounced memory (complete memory or recall of the past).
- Amnesia or loss of memory
- Paramnesia or falsification of memory (confused between reality and fantasy).
INTELLECTUAL ABILITY

The person’s ability to use facts comprehensively is an indication of intellectual ability.

During the assessment the person may be asked general information such as:

1. name the last three presidents
2. to calculate simple arithmetical problems
3. “to correctly estimate and form opinions concerning objective matters” (Small, 1980, p. 16).

The person may be asked a question such as “What would you do if you found a wallet in front of your house?”

The examiner is able to evaluate reasoning ability and judgments by the response given.

Abstract and concrete thinking abilities are evaluated by responses to proverbs such as “an eye for an eye and a tooth for a tooth.”
INSIGHT REGARDING ILLNESS OR CONDITION

Does the person consider him/her well or ill?
Does the patient understand what is happening?
Is the illness treating to the patients?

Insight is defined as self-understanding, or the extent of the one understands of the origin, nature, and behavior.

Patient’s insight into their illness or condition range from poor to good, depending on the degree of psychopathology present.
NEUROVEGETATIVE CHANGES

Does the patients exhibit change in psychophysiologic functions such as sleep patterns, eating patterns, energy levels, sexual functioning, or vowel functioning?

Depressed persons usually complain of insomnia or hypersomnia, loss of appetite or increased appetite, loss of energy, decreased libido, and constipation, which are all signs of neurovegetative changes.

Persons who are diagnosed as psychotic may neglect their nutritional intake, appear fatigued, sleep excessively, and ignore elimination habits (sometimes to the point of developing a fecal impaction.)
RECORDING OF ASSESSMENTS

Information obtained during the assessment process is relayed to the members of the health care team in the form of the summary of the history and physical examination, a summary of the social history, a summary of the psychological testing, and multidisciplinary progress notes.

Nurse can provide invaluable pertinent information if they follow the criteria of a good recording. Such information is significant to the members of the interdisciplinary team, who use these notes as an aid in planning treatment and disposition of patients.

Thorough charting shows progress, lack of progress, or regression on the part of the patient. The detail of the patients conduct, appearance and attitude are significant. Increased skill in observation and recording will result in more consist charting.

Charting is also important in research because it is an accurate record of the symptoms, behavior, treatment, and reactions of the patient.

Charting is recognized by legal authorities, who frequently use the notes for testimony in court.
The basic criteria for charting psychiatric nursing progress notes should be:

1. Objective: the nurse records what the patient says and does by stating facts and quoting the patient's conversation.

2. Descriptive: the nurse describes the patient's appearance, behavior and conversation as seen and heard.

3. Complete: a record of examinations, treatments, medications, therapies, nursing interventions, and the patient's reaction to each should be made on the patient's chart. Samples of the patient's writing or drawing should be preserved.

4. Legible: psychiatric nursing notes should be written legibly, with the use of acceptable abbreviations only, and no erasures. Correct grammar and spelling are important, and complete sentences should be used.

5. Dated: It is very important to note the time of entry. For example, MS has been quiet and withdrawn all days; however, later in the evening she becomes agitated. The nurse needs to state the time at which MS's behavior changed, as well as described any pertinent situation that might be identified as the cause of her behavioral change.


7. Signed: by the person making the entry.
Various forms of documentation are utilized to record nursing progress notes, including SOAP (subjective data, objective data, Assessment data, and plan of care) Progress notes should reflect the effectiveness of treatment plans.

Multidisciplinary progress notes have become more prevalent as they depict a chronological picture of the patient’s response to various therapeutic interventions.
An example of DAP nursing notes utilizing the multidisciplinary progress note format:

<table>
<thead>
<tr>
<th>Date And Time</th>
<th>Problem Number</th>
<th>Multidisciplinary Progress Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>07-06-09 9:00am</td>
<td>#1</td>
<td></td>
</tr>
</tbody>
</table>

D: RK was eating breakfast at 8:00am when she began to perspire profusely and stated, “I don’t know what’s wrong with me, but I feel jittery inside. I feel like something terrible is going to happen.” When asked to describe her feelings, RK replied, “I can’t. I just have an awful feeling inside.” Affect blunted. Pallor noted. Tearful during interaction. Minimal eye contact. Voice tremulous. P = 120, R = 38, BP = 130/80. No sign of acute physical distress noted at this time.

A: Expressing fear of the unknown and inability to maintain control of her emotions. Recognized she is experiencing symptoms of anxiety but unable to utilize effective coping skills.

P: Encourage verbalization of feelings when able to interact/communicate needs. Explore presence of positive coping skills. Administer prescribed anti-anxiety agent. Monitors response to medication.

- **Note:** problem #1 refers to *ineffective individual Coping*

- *NANDA approved nursing diagnosis.
REFERENCES:


Examples of Nursing Diagnosis:

- Body image disturbance
- Potential for violence, or self harm
- Social Isolation
- Ineffective Family Coping
- Impaired Grooming
- Self Care Deficit
- Knowledge Deficit
- Sensory Deficit
- Spiritual Deficit
- Sleep Pattern Disturbance
Related Learning Activities

I. Clinical Activities
   A. Assess the following areas of your assigned patient:
      1. Appearance
      2. Behavior
      3. Attitude
      4. Ability to communicate
      5. Emotional state or affect
      6. Content of thought
      7. Orientation
      8. Memory
      9. Intellectual Ability
      10. Insight regarding illness
   B. Summarize the data obtained to give an informative report about the patient’s mental health status.
   C. Chart pertinent information using descriptive, noninterpretive data.
II. Independent Activities
A. Use the following nonverbal behavior assessment guide while communicating with fellow students or friends:
   1. State any significant nonverbal behavior, such as finger tapping, tics, or poor eye contact.
   2. State the possible reason for or meaning of the behavior, such as fear, anxiety, boredom, or impatience.
B. List nursing interventions for the identified behavior.
III. Case Study Behavioral Assessment

A. WJ, 45-year-old patient admitted for emergency surgery for a bleeding ulcer, is referred to the psychiatric unit for a consultation because of symptoms of depression and anxiety. This married man has four children, two of whom are still living at home while attending college. He runs his own business and often works 10 to 12 hours each day. He had one previous hospitalization two years ago, when he had surgery for cancer of the colon.

WJ is alert and oriented in ICU but gets little sleep at night. While awake, he watches the nurses carefully and is very pleasant when he converses with them. When he calls for a nurse and one does not respond immediately, WJ begins to shout until someone arrives. His requests are often minor and he could have waited.

The staff is not certain how much WJ knows about his latest surgery, but his response is “I’m glad it wasn’t cancer. Maybe this happened to slow me down.” He usually terminates such discussions by stating that he has to rest and suggests that the attending staff care for other patients “who are sicker” than he is.

B. From the information given:

1. List the possible stressors before and during hospitalization.
2. Describe WJ present coping mechanisms.
3. While providing nursing care for WJ, identify stressors that the staff may experience.
4. Write informative nursing progress notes regarding WJ’s behavior.
<table>
<thead>
<tr>
<th>Question</th>
<th>MAXIMUM Score</th>
<th>Score</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ask the patient to name the year, season, date, day, and month. (1 point each)</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Ask the patient to give her/his whereabouts: state, country, town, street, floor. (1 point each)</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Ask the patient to repeat three unrelated objects that you name. Repeat them and continue to repeat them until all three are learned. (1 point each)</td>
<td>3</td>
<td></td>
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<tr>
<td>4. Ask the patient to subtract 7 from 100, stopping after five subtractions, or to spell the word “world” backwards. (1 point for each correct calculation or letter)</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Ask the patient to repeat the three objects previously named. (1 point each)</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Display a wrist watch and ask the patient to name it. Repeat this for a pencil. (1 point each)</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Ask the patient to repeat this phrase: “No ifs, ands, or buts!” (1 point)</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Have the patient follow a three-point command such as, “Take a paper in your night hand, fold it in half, and put it on the floor.” (1 point each)</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. On a blank piece of paper write, “Close your eyes!” ask the patient to read it and do what it says. (1 point)</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Ask the patient to write a sentence on a blank piece of paper. It must be written spontaneously. Score correctly if it contains a subject and a verb and is sensible (correct grammar and punctuation are not necessary) (1 point)</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Ask the patient to copy a design you have drawn on a piece of paper (two intersecting pentagons with sides about one inch). (1 point)</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Mental Status Exam - Elements

- APPEARANCE
  - Grooming /dress______________________
  - Hygiene________________________________
  - Eye Contact_________________________
  - Posture_____________________________
  - Identifying features (scars, tattoos)_____
  - Appearance versus stated age__________
  - Overall appearance____________________
BEHAVIOR/ACTIVITY

- Hyperactive___, Agitated___, Psychomotor retardation___, Calm___, Tremors___, Tics___, Unusual movements/gestures___, Catatonia___, Akathisia___, Rigidity___, Facial movements(jaw/lip smacking)___, Other________
SPEECH

- Slow/rapid___, Pressured___, Tone___, Volume(loud/soft)___, Fluency(mute, hesitation, latency of response)___
Attitude

- Cooperative___, Uncooperative___
- Warm and friendly____, Distant___
- Suspicious___, Guarded___,
- Aggressive___, Hostile___, Combative___
- Apathetic___, Aloof___
- Other__________________
MOOD AND AFFECT

- **MOOD** – (general feeling) Observe and listen

- **Elated**, Sad, Depressed, Irritable, Anxious, Fearful, Guilty, Worried, Angry, Hopeless, Labile, Mixed (anxious and Depressed)
MOOD AND AFFECT (cont.)

- AFFECT – facial expression
  - Flat, Blunted or diminished,
  - Full range,
  - Inappropriate/incongruent (sad and smiling laughing) e.g.: Smiling at a funeral of a loved one when time to be serious. Facial expression does not fit with the topic being discussed.
THOUGHT PROCESS

- Cognition – How the patient thinks, thinking processes
- Concrete thinking__, Circumstantiality__, Tangentiality__, Loose associations__, Flight of ideas__, Perserveration__, Blocking__, Derailment__,
- (Echolalia, Clang associations, Word salad – not seen often)
- Other__________
Thought Content

- What the patient says
- Delusions
- (Gradiose / persecutory/reference/ somatic), Homocidal - to whom?
- Suicidal – describe
- Obsessions
- Paranoia
- Phobias
- Magical thinking
- Poverty of speech
- Other
PERCEPTUAL DISTURBANCE

- Visual hallucinations___, Auditory___
- commenting___, discussion___, commanding___, loud___, soft___, other_________

Other hallucination (Olfactory / tactile)
Illusions___, Depersonalization___,
Other_________
MEMORY/COGNITION

- Orientation___,
- Memory (Recent/remote/confabulation)____,
- Level of alertness (Level of consciousness)___
INSIGHT AND JUDGEMENT

- Insight (awareness of the nature of the illness)
- Judgment  “What would you do if you saw a letter on the ground with a stamp on it?” Are discharge plans appropriate to pt’s income, ability to work, current roles and capabilities?
- Impulse control
- Other
DSM-IV-TR MULTIAXIAL CLASSIFICATION

- **Axis I:** Clinical DO, Major Psychiatric DX
- **Axis II:** Personality DO, (Traits also)/Mental Retardation
- **Axis III:** Medical Conditions
- **Axis IV:** Psychosocial/Environmental Stressors
- **Axis V:** Global Assessment of Functioning (GAF) Current__, Past year, highest level___, Admission___, Discharge___ Scale: 0 - 100
DSM-IV-TR (cont.)

- Axis I: Patient must meet specific criteria in order to receive a diagnosis.
- Not diagnoses of exclusion.
- May need to evaluate patient over time (with help of nursing, social work, psychologist), holistically, using a variety of sources.
Documentation of the Nursing Process

- Documentation of the steps of the nursing process is often considered as evidence in determining certain cases of negligence by nurses.
- It is also required by some agencies that accredit health care organizations.
Documentation of the Nursing Process

- **Focus Charting**
  - Main perspective is to choose a “focus” for documentation. A focus may be:
    - a nursing diagnosis
    - a current client concern or behavior
    - a significant change in the patient’s status or behavior
    - a significant event in the patient’s treatment
  - The focus cannot be a medical diagnosis.
Documentation

- **BIRP**
- **Behavior/Assess/What the patient is saying and doing**
- **Interventions**
- **Response/What the patient said or did as a result of the intervention**
- **Plan/Where to go next/What does the patient need next**
Problem-oriented recording (SOAPIE):

- **Subjective data** = information gathered from what the client, family, or other source has said or reported
- **Objective data** = information gathered by direct observation
- **Assessment** = nurse’s interpretation of the subjective and objective data
- **Plan** = actions/treatment to be carried out
- **Intervention** = nursing actions actually carried out
- **Evaluation** = assessment of the problem following nursing interventions
Focus charting (DAR and AIR):

- **Data** = information that supports the focus or describes pertinent observations
- **Action** = nursing actions that address the focus
- **Response** = description of client’s response to any part of the medical or nursing care

______________________________

- **Assessment** = observations about the client
- **Intervention** = nursing actions that address the observations
- **Response** = client’s response to actions
Quality Documentation

- Specific and descriptive
- No assumptions or hunches – just the facts
- Use the patients words at times to highlight and clarify
- No need to say “Pt” or “Client” – the whole chart is about the patient
- Only chart what you see and hear now, as patients change
- Avoid the use of “I”. Instead “This writer”