

APPENDIX C

COURSE OUTLINE AND ASSIGNMENTS

Unit I FOUNDATIONS IN PSYCHIATRIC NURSING

OBJECTIVES:

1. Recognize structure and functional interrelationship of the mind-body-spirit connection of clients experiencing stressors related to psychiatric mental health nursing.
2. Describe selected pathological conditions that manifest with clients experiencing stressors related to psychiatric mental health nursing.
3. Synthesize principles from the biological, physical and behavioral sciences, the humanities, spirituality and nursing in the process of caring for clients experiencing stressors related to psychiatric mental health nursing.
4. Implement appropriate supportive, alternative and rehabilitative measures based on assessment of needs and or/deficits, to promote a maximum level of wellness among clients experiencing stressors related to psychiatric mental health nursing.
5. Utilize nursing roles for enhancing the quality of care among mental health clients experiencing stressors related to psychiatric mental health nursing.
6. Utilize knowledge from nursing research of clients experiencing stressors related to psychiatric mental health nursing.
7. Demonstrate accountability in meeting the needs for self-development and acquisition of knowledge concerning clients experiencing stressors related to psychiatric mental health nursing.
8. Recognize management and leadership styles in the delivery of care to clients, families, and/or significant others related to clients experiencing stressors related to psychiatric mental health nursing.
9. Utilize guided direction and self-direction, safe practice, and critical thinking to responsibly meet the needs of clients experiencing stressors related to psychiatric mental health nursing.
10. Implement the nursing process in caring for clients experiencing stressors related to psychiatric mental health nursing
11. Demonstrate effective communication techniques in caring for clients experiencing stressors related to psychiatric mental health nursing.

UNIT 1. **Foundations in Psychiatric Nursing**

- A. Integration of Self and Professional Role
 - 1. Personal integration
 - 2. Taking care of self
 - 3. Qualities of the effective psychiatric mental health nurse
 - 4. Professional roles of the psychiatric mental health nurse
 - 5. Collaboration of the mental health team

- B. Theoretical Perspective
 - 1. Mind, body and spirit connection
 - 2. Psychoanalytical Theory
 - 3. Behavior Theory
 - 4. Social Interpersonal Theories
 - 5. Nursing Theorists

- C. Evidenced Based Nursing
 - 1. Conditions mandating evidenced based practice
 - 2. What is evidenced-based practice
 - 3. Sarah Cole Hirsch Instituted for Best Practices based on evidence
 - 4. Context for evidence-based practice
 - 5. Rossworn and Larrabee Model for Change
 - 6. Building a knowledge base for evidence-based practice

- D. Psychobiology
 - 1. Brain, mind, and behavior
 - 2. Psychobiology and Mental Disorders
 - 3. Psychobiology and Nursing

- E. Stress, Anxiety and Coping
 - 1. Stress
 - a. Ways to cope
 - b. Coping resources
 - c. Defense mechanisms
 - 2. Biopsychosocial theories of stress
 - 3. Anxiety
 - a. Levels of anxiety
 - 4. Conditions affected by psychological factors

- F. Cultural Issues
 - 1. Cultural Competence
 - 2. Epidemiology
 - 3. Recent Developments

UNIT 1: Foundations of Psychiatric Nursing

CLASS 1

Enabling Objectives	Resources and Learning Experiences
<p><u>Integration of Self and Professional Role</u></p> <ol style="list-style-type: none"> 1. Relate the concept of personal integration to self and to psychiatric mental health nursing 2. Explain why psychiatric professional must confront their own identity 3. Describe the qualities that enable psychiatric mental health nurses to practice the use of self artfully in therapeutic relationships 4. Compare and contrast the roles of the psychiatric mental health nurse with other members of the mental health care team. <ol style="list-style-type: none"> a) Basic b) Advanced Practice c) The Mental Health Team 5. Describe how to incorporate qualities of effective psychiatric mental health nursing in professional practice. 	<p>Text Chapter 1, p 1-22 www.prenhall.com/kneisl Student CD Rom (Independent Study)</p>
<p><u>Theoretical Perspective</u></p> <ol style="list-style-type: none"> 1. Describe theoretical approaches in psychiatric mental health nursing. <ol style="list-style-type: none"> a. Medical – Psychobiologic theory b. Psychoanalytic Theory c. Behaviorist theory d. Social Interpersonal Theories 2. Discuss implications each theory has for psychiatric mental health nursing. 3. Identify nursing theorist that have influenced the concepts related to mental health care 4. Describe the application of these interdisciplinary principles to professional practice 	<p>Text Chapter 2, p 27-41 www.prenhall.com/kneisl Student CD Rom (Independent Study) Table 2-5 Page 38</p>
<p><u>Evidenced Based Nursing</u></p> <ol style="list-style-type: none"> 1. Define “evidenced-based” psychiatric mental health nursing practice 2. Describe the importance of critical thinking in evidenced-based practice 	<p>Text Chapter 3, 45-52 www.prenhall.com/kneisl Student CD Rom (Independent Study) Figure 3-3 page, 49</p>

Enabling Objectives	Resources and Learning Experiences
<p><u>Psychobiology</u></p> <ol style="list-style-type: none"> 1. Recognize how the neuroanatomic structures affect thought, behavior, memory, understanding of consequences, and emotions 2. Describe neurotransmitter alterations that occur in major psychiatric disorders 3. Discuss the importance of teaching client/families about the psychobiologic aspects of psychiatric illnesses. 	<p>Text Chapter 4, 69-79 www.prenhall.com/kneisl Student CD Rom (Independent Study) Independent Study- Neuroanatomy pp 59-69 Table 4-1; p 70 Table 4-2, p 71 Table 4-3, p 71</p>
<p><u>Stress, Anxiety and Coping</u></p> <ol style="list-style-type: none"> 1. Describe the effects of stress and anxiety on the individual. 2. Describe the sources of stress and anxiety 3. Identify common defense mechanisms people use to cope with stress and anxiety 4. Discuss the various levels of stress 5. Describe conditions affected by psychological factors 	<p>Text Chapter 5, pp. 80-107 www.prenhall.com/kneisl Student CD Rom (Independent Study) Figure 5-3, p 84 Table 5-1, p 94 Table 5-2, p 101</p>
<p><u>Cultural Issues</u></p> <ol style="list-style-type: none"> 1. Define cultural competence 2. Discuss why understanding psychiatric epidemiology is important in our culturally diverse society 3. Understand the relationship of the natural life history of disorder and treatment 	<p>Text Chapter 6, pp. 110-127 www.prenhall.com/kneisl Student CD Rom (Independent Study) Figure 6-4, p 123</p>

UNIT 2:**KEY PROCESSES AND COMPETENCIES****OBJECTIVES:**

1. Recognize structure and functional interrelationship of the mind-body-spirit connection of clients needing application of the nursing process.
2. Describe selected pathological conditions that manifest with clients experiencing stressors related to psychiatric mental health nursing.
3. Synthesize principles from the biological, physical and behavioral sciences, the humanities, spirituality and nursing in the process of caring for clients experiencing stressors related to psychiatric mental health nursing.
4. Implement appropriate supportive, alternative and rehabilitative measures based on assessment of needs and or/deficits, to promote a maximum level of wellness among clients experiencing stressors related to:
5. Utilize nursing roles for enhancing the quality of care among mental health clients experiencing stressors related to psychiatric mental health nursing.
6. Utilize knowledge from nursing research of clients experiencing stressors related to psychiatric mental health nursing.
7. Demonstrate accountability in meeting the needs for self-development and acquisition of knowledge concerning clients experiencing stressors related to psychiatric mental health nursing.
8. Recognize management and leadership styles in the delivery of care to clients, families, and/or significant others related to clients experiencing stressors related to psychiatric mental health nursing.
9. Utilize guided direction and self-direction, safe practice, and critical thinking to responsibly meet the needs of clients experiencing stressors related to psychiatric mental health nursing.
10. Implement the nursing process in caring for clients experiencing stressors related to psychiatric mental health nursing
11. Demonstrate effective communication techniques in caring for clients experiencing stressors related to psychiatric mental health nursing.

UNIT 2. Applying Psychiatric Mental Health Nursing Processes and Competencies

- A. The Nursing Process with Psychiatric Mental Health Clients
 - 1. Standard I : Assessment
 - 2. Standard II: Diagnosis
 - 3. Standard III: Outcome Identification
 - 4. Standard IV: Planning
 - 5. Standard V: Implementation
 - 6. Standard VI: Evaluation

- B. Therapeutic Communication
 - 1. Process of Human Communication
 - a. Role of Perception
 - b. Role of Values
 - c. Role of Culture
 - d. The Spoken Word
 - e. Nonverbal Messages

 - 2. Facilitative communication
 - a. Responding with Empathy
 - b. Responding with Respect
 - c. Responding with Genuineness
 - d. Responding with Immediacy
 - e. Responding with Warmth

 - 3. Facilitative communication skills
 - a. Empathizing
 - b. Actively Listening
 - c. Using Silence
 - d. Reflecting
 - e. Imparting Information
 - f. Clarifying
 - g. Paraphrasing
 - h. Checking Perceptions
 - i. Questioning
 - j. Structuring
 - k. Pinpointing
 - l. Linking
 - m. Giving Feedback
 - n. Confronting
 - o. Summarizing
 - p. Processing

- C. Assessment
 - 1. Psychiatric History
 - 2. Mental Status Examination
 - 3. Multiaxial System
 - 4. Psychosocial Assessment

- D. Clients' Rights, Ethics, and Advocacy
 - 1. Admissions and Commitment Criteria
 - 2. Psychiatric Advance Directives
 - 3. Informed Consent
 - 4. Right to Refuse Treatment
 - 5. Client Advocacy

- E. Creating a Therapeutic Environment

UNIT 2: Applying Psychiatric-Mental Health Nursing Processes

CLASS 1

Enabling Objectives	Resources and Learning Experiences
<p><u>The Nursing Process with Psychiatric – Mental Health Clients (Lab)</u></p> <ol style="list-style-type: none"> 1. Differentiate the various phases of the nursing process as related to psychiatric mental health nursing 2. Connect how the American Nurses Association Standards of Psychiatric-Mental Health Nursing practice are related to the nursing process. 	<p>Chapter 7, pp131-140 www.prenhall.com/kneisl Student CD Rom (Independent Study) Box 7-1, p 135-136</p>
<p><u>Therapeutic Communication (Lab)</u></p> <ol style="list-style-type: none"> 1. Identify what factors influence the process of human communication 2. Apply principles of communication as related to psychiatric mental health nursing <ol style="list-style-type: none"> a) Facilitative communication b) Facilitative communication skills 	<p>Text Chapter 8, pp. 142-159 www.prenhall.com/kneisl Student CD Rom (Independent Study) Figure 8-3, p 146 Box 8-1, p 154 Interventions, p 157 Box 8-2, p 159</p>
<p><u>Assessment (Lab)</u></p> <ol style="list-style-type: none"> 1. Compare and contrast the various kinds of assessments used in psychiatric mental health nursing 2. Complete a mental status examination including the multiaxial system 	<p>Text Chapter 9, pp. 110-127 www.prenhall.com/kneisl Student CD Rom (Independent Study) Box 9-6 and 9-7, p 173 Box 9-8, p 174</p>
<p><u>Client’s Rights, Ethics and Advocacy (Class I)</u></p> <ol style="list-style-type: none"> 1. Discuss legal, ethical issues in psychiatric mental health nursing 2. Use the principles of bioethics as they relate to psychiatric mental health nursing 3. Know the role of the psychiatric nurse in advocating for the client/family/etc. 	<p>Text Chapter 10, pp. 181-205 www.prenhall.com/kneisl Student CD Rom (Independent Study) Box 10-2 and 10-3, p 183 Box 10-4, p 189 Box 10-7, p 196 Box 10-9 and 10-10, p 201</p>
<p><u>Creating a Therapeutic Environment (Class I)</u></p> <ol style="list-style-type: none"> 1. Compare and contrast the types of treatment services and programs 2. Discuss the therapeutic environment <ol style="list-style-type: none"> a) External factors affecting the environment b) Applying therapeutic principles 	<p>Text Chapter 11, pp. 209-231 www.prenhall.com/kneisl Student CD Rom (Independent Study) Guidelines for working with clients in the therapeutic environment, p 221.</p>

UNIT 3**Clients with Mental Disorders:**

- A. Cognitive disorders**
- B. Substance-Related disorders**
- C. Schizophrenia and other psychiatric disorders**
- D. Mood disorders**
- E. Anxiety, Somatoform, and Dissociative Disorders**
- F. Gender Identity**
- G. Eating Disorders**
- H. Sleep Disorders**
- I. Personality Disorders**
- J. Coexisting Psychiatric and Substance Use Disorders**

OBJECTIVES

1. Recognize structure and functional interrelationship of the mind-body-spirit connection of clients experiencing stressors related to psychiatric mental health disorder.
2. Describe selected pathological conditions that manifest with clients experiencing stressors related to psychiatric mental health disorder.
3. Synthesize principles from the biological, physical and behavioral sciences, the humanities, spirituality and nursing in the process of caring for clients experiencing stressors related to psychiatric mental health disorder.
4. Implement appropriate supportive, alternative and rehabilitative measures based on assessment of needs and or/deficits, to promote a maximum level of wellness among clients experiencing stressors related to psychiatric mental health disorder.
5. Utilize nursing roles for enhancing the quality of care among mental health clients experiencing stressors related to psychiatric mental health nursing.
6. Utilize knowledge from nursing research of clients experiencing stressors related to psychiatric mental health disorder.
7. Demonstrate accountability in meeting the needs for self-development and acquisition of knowledge concerning clients experiencing stressors related to psychiatric mental health disorder.
8. Recognize management and leadership styles in the delivery of care to clients, families, and/or significant others related to clients experiencing stressors related to psychiatric mental health disorder.

9. Utilize guided direction and self-direction, safe practice, and critical thinking to responsibly meet the needs of clients experiencing stressors related to psychiatric mental health disorder.
10. Implement the nursing process in caring for clients experiencing stressors related to psychiatric mental health disorder.
11. Demonstrate effective communication techniques in caring for clients experiencing stressors related to psychiatric mental health disorder.

UNIT 3 **Clients with Mental Disorders**

- A. Cognitive disorders
 - 1. Delirium
 - 2. Dementia
 - 3. Nursing Process: Clients with Cognitive Disorders

- B. Substance-Related disorders
 - 1. Substance Dependence
 - 2. Substance Abuse
 - 3. Substance Intoxication
 - 4. Substance Withdrawal
 - 5. Theories
 - 6. Substance: Alcohol
 - 7. Substance: Barbiturates, Sedatives and Hypnotics
 - 8. Substance: Opioids
 - 9. Substances: Amphetamines
 - 10. Substance: Cannabis
 - 11. Substance: Cocaine
 - 12. Substance: Crack
 - 13. Substance: Hallucinogen
 - 14. Substance: Inhalants
 - 15. Substance: Nicotine
 - 16. Substance: Caffeine
 - 17. Groups at Risk for Substance Abuse
 - 18. Nursing Process: Clients with Substance-Related Disorders

- C. Schizophrenia and other psychiatric disorders
 - 1. Positive symptoms of Schizophrenia
 - 2. Negative symptoms of Schizophrenia
 - 3. Subtypes of Schizophrenia
 - a. Paranoid
 - b. Disorganized
 - c. Catatonic
 - d. Undifferentiated
 - e. Residual
 - f.
 - 4. Other Psychotic Disorders
 - a. Schizoaffective disorder
 - b. Delusional Disorder
 - c. Brief Psychotic Disorder
 - 5. Theories
 - 6. Nursing Process: Clients with Schizophrenia

- D. Mood disorders
 - 1. Major Depressive Disorder
 - 2. Dysthmic Disorder
 - 3. Seasonal Affective Disorder (SAD)
 - 4. Bipolar Disorders
 - a. Mania and Hypomanic Episodes
 - b. Depressed episodes
 - c. Mixed Episodes
 - 5. Cyclothymic Disorder
 - 6. Mood Disorders due to other conditions
 - 7. Theories
 - 8. Nursing Process: Clients with Major Depressive Disorder
 - 9. Nursing Process: Clients with Bipolar Disorders

- E. Anxiety, Somatoform, and Dissociative Disorders
 - 1. Anxiety Disorders
 - a. Panic disorder
 - b. Phobic disorders
 - c. Agoraphobia
 - d. Social Phobia
 - e. Specific Phobia
 - f. Generalized Anxiety Disorder (GAD)
 - g. Obsessive-compulsive Disorder
 - h. Post Traumatic Stress Disorder (PTSD)
 - i. Theories
 - j. Nursing Process of Clients with Anxiety Disorders
 - 2. Somatoform Disorders
 - a. Somatization Disorder
 - b. Conversion Disorder
 - c. Pain Disorder
 - d. Hypochondriasis
 - e. Theories related to Somatoform Disorders
 - f. Nursing Process of Clients with Somatoform Disorders
 - 3. Dissociative Disorders
 - a. Dissociative Identity Disorder
 - b. Depersonalization Disorder
 - c. Theories related to dissociative disorders
 - d. Nursing Process of Clients with Dissociative Disorder

- F. Gender Identity
 - 1. Transgenderism
 - 2. Gender Identity
 - 3. Gender Roles
 - 4. Androgyny
 - 5. Transsexuals
 - 6. Cross Dressers

7. Transvestic Fetishism
 8. Exhibitionism, Voyerism, and Frotteurism
 9. Theories related to gender identity
 10. Nursing Process of clients with gender identity
- G. Eating Disorders
1. Bulimia Nervosa
 2. Binge-eating disorder
 3. Theories related to eating disorders
 4. Nursing Process of clients with eating disorders
- H. Sleep Disorders
1. Primary Insomnia
 2. Primary Hypersomnia
 3. Sleep apnea
 4. Narcolepsy
 5. Theories related to sleep disorders
 6. Nursing Process of clients with sleep disorders
- I. Personality Disorders
1. Cluster A
 - a. Paranoid Personality Disorder
 - b. Schizoid Personality Disorder
 - c. Schizotypal Personality Disorder
 2. Cluster B
 - a. Borderline Personality Disorder
 - b. Histrionic Personality Disorder
 - c. Narcissistic Personality Disorder
 - d. Antisocial Personality Disorder
 3. Cluster C
 - a. Avoidant Personality Disorder
 - b. Dependent Personality Disorder
 - c. Obsessive-Compulsive Personality Disorder
 4. Theories related to Personality Disorder
 5. Nursing Process of Clients with Personality Disorders
- J. Coexisting Psychiatric and Substance Use Disorders
1. Dual Diagnosis- problematic term
 2. Characteristics of clients with Coexisting disorders
 3. Nursing Process of clients with Coexisting Psychiatric and Substance Use Disorders

UNIT 3: Clients with Mental Disorders

CLASS 2 (Cognitive and Substance use disorders)

Enabling Objectives	Resources and Learning Experiences
<ol style="list-style-type: none"> 1. Describe the signs and symptoms related to clients with substance abuse. 2. Examine the various theories related to clients experiencing stressors related to cognitive disorders and substance use disorders 3. Formulate the plan of care for clients experiencing stressors related to cognitive disorders and substance use disorders 	<p>Chapter 12, pp 236-259 Diagnostic Criteria for Cognitive Disorders – table p 237 Table 12-1, p 239 Box 2-1, p 241 Assessment of DAT, p 242 Case Study: client with delirium pp 250-251 Case Study: client with dementia, pp254-255</p> <p>Chapter 13, pp 261-303 Diagnostic Criteria for Substance Abuse vs. Substance Dependence ,p 265 Diagnostic Criteria for Substance Intoxication and Withdrawal, p 265 Figure, 13-1, p 267 Table 13-2, p 270 Box 13-4, p 273 Box 13-5, p 274 Box 13-6, p 276 Box 13-7, p 278 Box 13-9, p 281 Box 13-10, p 282 Box 13-11, p 283 Box 13-12, p 284 Table 13-4, p 286 Box 13-13, p 290 Case Study: Client with Chronic Alcoholism, p 292-293</p> <p>www.prenhall.com/kneisl Student CD Rom (Independent Study)</p>

UNIT 3: Clients with Mental Disorders**CLASS 3 Psychoses and Mood Disorders**

Enabling Objectives	Resources and Learning Experiences
<ol style="list-style-type: none"> 1. Describe the signs and symptoms related to clients with psychoses and mood disorders 2. Examine the various theories related to clients experiencing stressors related to psychoses and mood disorders 3. Formulate the plan of care for clients experiencing stressors related to psychoses and mood disorders 	<p>Chapter 14, pp 306-333 Table 14-2, p 308 Table 14-3, p 309 Table 14-4, p 310 Box 14-4, p 319 Box 14-2, p 323 Case Study: client with Schizophrenia</p> <p>Chapter 15, pp 335-365 Figure 15-1, p 339 Figure 15-2, p 341 Client/Family Teaching p 352 and 354 Case Study: Client with Depression</p> <p>www.prenhall.com/kneisl Student CD Rom (Independent Study)</p>

UNIT 3: Clients with Mental Disorders**CLASS 4 Anxiety , somatoform and dissociative disorders; gender identity**

Enabling Objectives	Resources and Learning Experiences
<ol style="list-style-type: none"> 1. Describe the signs and symptoms related to clients with anxiety, somatoform and dissociative disorders; and clients with gender identity. 2. Examine the various theories related to clients experiencing stressors related to anxiety, somatoform and dissociative disorders; and clients with gender identity. 3. Formulate the plan of care for clients experiencing stressors related to anxiety, somatoform and dissociative disorders; and clients with gender identity. 	<p>Ch 16, pp 368-399 Table 16-1, p 368 Table 16-3, p 374 Figure 16-1, p 376 Table 16-4, p 378 Intervention Tables, pp 384-385 Table 16-5, p 386</p> <p>Chapter 17, pp 401-406 Chapter 17, pp 415-423 Nursing Self Awareness checklist, p 403 DSM-IV-TR, ,pp 404-406</p> <p>www.prenhall.com/kneisl Student CD Rom (Independent Study)</p>

UNIT 3: Clients with Mental Disorders

CLASS 5 Eating Disorders, Sleep Disorders, Personality Disorders, and Coexisting Psychiatric and Substance Use Disorders

Enabling Objectives	Resources and Learning Experiences
<ol style="list-style-type: none"> 1. Describe the signs and symptoms related to clients with eating disorders, sleep disorders, personality disorders and coexisting psychiatric and substance use disorders 2. Examine the various theories related to clients experiencing stressors related eating disorders, sleep disorders, personality disorders and coexisting psychiatric and substance use disorders 3. Formulate the plan of care for clients experiencing stressors related eating disorders, sleep disorders, personality disorders and coexisting psychiatric and substance use disorders 	<p>Ch 16, pp 368-399 Table 16-1, p 368 Table 16-3, p 374 Figure 16-1, p 376 Table 16-4, p 378 Intervention Tables, pp 384-385 Table 16-5, p 386</p> <p>Chapter 17, pp 401-406 Chapter 17, pp 415-423 Nursing Self Awareness checklist, p 403 DSM-IV-TR, pp 404-406</p> <p>Chapter 18, 427-450 Figure 18-1, p 433 Client/Family Teaching, p 443 Case Study: Client with Bulimia Nervosa, pp 444-446</p> <p>Chapter 19, pp 456-461,, 466-477 Intervention chart, p 437 Table 19-2, p 470</p> <p>Chapter 20, pp 480-505 DSM-IV-TR, pp 480-483 Case Study: Client with Borderline Personality Disorder, pp490-492 Guidelines for Clients with Manipulative Behaviors, p 500 Guidelines for Clients with Dependent Personality Disorder, p 501 Guidelines for Clients with Aggressive Behavior, p 502 Guidelines for Clients with Paranoid Personality Disorder, p 503 Guideline for the client with antisocial personality disorder, p 503</p>

Enabling Objectives	Resources and Learning Experiences
	Chapter 21, pp 506-523 Figure 21-3,p 509 Communication, p 513 Assessment, p 514 Intervention, p 519 Case Study: Client with Coexisting Psychiatric and Substance Use Disorders, p 520-521 www.prenhall.com/kneisl Student CD Rom (Independent Study)

UNIT 4:**Vulnerable Populations****OBJECTIVES:**

1. Recognize structure and functional interrelationship of the mind-body-spirit connection of clients needing application of the nursing process.
2. Describe selected pathological conditions that manifest with clients experiencing stressors related to psychiatric mental health nursing needs of vulnerable populations.
3. Synthesize principles from the biological, physical and behavioral sciences, the humanities, spirituality and nursing in the process of caring for clients experiencing stressors related to psychiatric mental health nursing needs of vulnerable populations.
4. Implement appropriate supportive, alternative and rehabilitative measures based on assessment of needs and or/deficits, to promote a maximum level of wellness among clients experiencing stressors related to psychiatric mental health needs of vulnerable populations.
5. Utilize nursing roles for enhancing the quality of care among mental health clients experiencing stressors related to vulnerable populations.
6. Utilize knowledge from nursing research of clients experiencing stressors related to psychiatric mental health nursing needs of vulnerable populations.
7. Demonstrate accountability in meeting the needs for self-development and acquisition of knowledge concerning clients experiencing stressors related to psychiatric mental health nursing needs of vulnerable populations.
8. Recognize management and leadership styles in the delivery of care to clients, families, and/or significant others related to clients experiencing stressors related to psychiatric mental health nursing needs of vulnerable populations.
9. Utilize guided direction and self-direction, safe practice, and critical thinking to responsibly meet the needs of clients experiencing stressors related to psychiatric mental health nursing needs of vulnerable populations.
10. Implement the nursing process in caring for clients experiencing stressors related to psychiatric mental health nursing needs of vulnerable populations.
11. Demonstrate effective communication techniques in caring for clients experiencing stressors related to psychiatric mental health nursing needs of vulnerable populations.

UNIT 4**Vulnerable Populations**

- A. Clients at Risk for Suicide and Self Destructive Behavior
 - 1. Direct and Indirect Self –Destructive Behavior
 - 2. Theories
 - 3. Nursing Process related to suicide and self-destructive behavior
- B. Persons at Risk for Abuse or Violence
 - 1. Rape
 - 2. Intrafamily Violence
 - 3. Partner Abuse-Heterosexual
 - 4. Partner Abuse- Homosexual
 - 5. Elder Abuse
 - 6. Cycle of Violence
 - 7. Theories
 - 8. Nursing Process related to persons at risk for abuse or violence
- C. Psychiatric-Mental Health Clients with HIV/AIDS
 - 1. Roles for Psychiatric-Mental Health Nurses
- D. Children
 - 1. Developmental Disorders
 - 2. Attention Deficit and Disruptive Behavior Disorders
- E. Adolescents
 - 1. The role of the Nurse
 - 2. Substance Abuse
 - 3. Suicide
- F. Elders
 - 1. Depression in the elderly
 - 2. Suicide among elders
 - 3. Substance related disorders

UNIT 4: Vulnerable Populations**CLASS 6 Clients at Risk for Suicide and Self-Destructive Behavior**

Enabling Objectives	Resources and Learning Experiences
<ol style="list-style-type: none"> 1. Relate nursing care to the management of clients at risk for suicide and destructive behaviors. 2. Recognize the importance of completing a lethal assessment 3. Complete plan of care for client at risk for suicide and self-destructive behavior 	<p>Chapter 22, pp 529-531, 534-542 Lethality Assessment Scale, p 535 Intervention- How to Develop No Self-Harm/No Suicide Contracts</p> <p>www.prenhall.com/kneisl Student CD Rom (Independent Study)</p>

CLASS 6 Persons at Risk for Abuse or Violence

Enabling Objectives	Resources and Learning Experiences
<ol style="list-style-type: none"> 1. Relate the nursing care to the management of clients at risk for the abuse or violence 2. Discuss case of an adult survivor of childhood sexual abuse 	<p>Chapter 23, pp 545-570 Box 23-1, p 544 Nursing Self-Awareness: Working with Rape Victims, p 549 Box 23-2, p 555 Nursing Self Awareness: Working with Victims of Child Sexual Abuse, p 560 Case Study: An Adult Survivor of Childhood Sexual Abuse</p> <p>www.prenhall.com/kneisl Student CD Rom (Independent Study)</p>

UNIT 4: Vulnerable Populations

CLASS 6 Psychiatric-Mental Health Clients with HIV/AIDS

Enabling Objectives	Resources and Learning Experiences
<ol style="list-style-type: none"> 1. Identify the certain psychiatric populations at risk for AIDS 2. Select which modifications would be made in providing direct care to people with HIV disease in psychiatric setting 3. Related nursing care to the management of clients with AIDS 4. Identify support for caregivers 	Chapter 24, pp 573-576, 580-586 Nursing Self-Awareness: Ethical Issues Surrounding HIV/AIDS www.prenhall.com/kneisl Student CD Rom (Independent Study)

UNIT 4: Vulnerable Populations

CLASS 6 Children

Enabling Objectives	Resources and Learning Experiences
<ol style="list-style-type: none"> 1. Discuss how to conduct an assessment of a child with a mental health problems 2. Relate nursing care of the management of children with psychiatric mental health disorders 	Chapter 25, pp591-595, pp 602-613 Assessment- Guidelines for Children, p 604 Box 25-2, p 605 www.prenhall.com/kneisl Student CD Rom (Independent Study)

UNIT 4: Vulnerable Populations

CLASS 6 Adolescents

Enabling Objectives	Resources and Learning Experiences
<ol style="list-style-type: none"> 1. Recognize why a humanistic interactionist perspective is important in the comprehensive assessment of adolescent problems 2. Distinguish the various roles of the nurse in caring for adolescents in multiple settings 3. Relate nursing care of the management of adolescents with psychiatric mental health disorders 	Chapter 26, p 618-637 Nursing Self-Awareness- A self-awareness inventory for working with adolescents, p 626 Box 26-4, p 629 www.prenhall.com/kneisl Student CD Rom (Independent Study)

UNIT 4: Vulnerable Populations

CLASS 6 Elders

Enabling Objectives	Resources and Learning Experiences
<ol style="list-style-type: none">1. Relate nursing care to the management of the aged client with psychiatric mental health disorder2. Describe the theories of aging and the major ideas associated with each of them3. Identify community supports for elders	Chapter 27, 641-657. Table 27-1, p 653 Table 27-2, p 655 www.prenhall.com/kneisl Student CD Rom (Independent Study)

UNIT 5:**Nursing Intervention Strategies and Outcomes****OBJECTIVES:**

1. Recognize structure and functional interrelationship of the mind-body-spirit connection of clients needing application of the nursing process.
2. Synthesize principles from the biological, physical and behavioral sciences, the humanities, spirituality and nursing in the process of caring for clients experiencing stressors related to psychiatric mental health nursing intervention strategies and outcomes.
3. Implement appropriate supportive, alternative and rehabilitative measures based on assessment of needs and or/deficits, to promote a maximum level of wellness among clients.
4. Utilize nursing roles for enhancing the quality of care among mental health clients experiencing stressors related to psychiatric mental health nursing.
5. Utilize knowledge from nursing research of clients experiencing stressors related to psychiatric mental health nursing needs.
6. Demonstrate accountability in meeting the needs for self-development and acquisition of knowledge concerning clients experiencing stressors related to psychiatric mental health nursing needs.
7. Recognize management and leadership styles in the delivery of care to clients, families, and/or significant others related to clients experiencing stressors related to psychiatric mental health nursing needs.
8. Utilize guided direction and self-direction, safe practice, and critical thinking to responsibly meet the needs of clients experiencing stressors related to psychiatric mental health nursing needs.
9. Implement the nursing process in caring for clients experiencing stressors related to psychiatric mental health nursing needs of vulnerable populations.
10. Demonstrate effective communication techniques in caring for clients experiencing stressors related to psychiatric mental health nursing needs.

UNIT 5 Nursing Intervention Strategies and Outcomes

- A. Counseling the Individual
 - 1. The One-to-one Relationship
 - 2. Phenomena Occurring in One-to-one relationships
 - 3. Nursing Process

- B. Group and Family Interventions
 - 1. Small Group Dynamics
 - 2. Three Basic Interpersonal Needs
 - 3. Group Phases
 - 4. Therapeutic Groups
 - 5. Family Assessment

- C. Cognitive and Behavioral Interventions
 - 1. Cognitive Therapy
 - 2. Behavior Therapy
 - 3. Cognitive-Behavior Therapy
 - 4. Nursing Process

- D. Psychopharmacology
 - 1. Assessment of the client taking psychiatric medication
 - 2. Neuroleptics and Psychotropics
 - 3. Antidepressant Medications
 - 4. Anxiolytic Medications

- E. Complementary and Alternative Healing Practices (CAM)
 - 1. Nursing Role in CAM

- F. Crisis Intervention
 - 1. Crisis as disequilibrium
 - 2. Theories
 - 3. Nursing Process

- G. Intervening in Violence in the Psychiatric Setting
 - 1. Nursing Process

- H. Forensic Psychiatric Nursing

UNIT 5: Nursing Intervention Strategies and Outcomes

CLASS 6 Counseling the Individual

Enabling Objectives	Resources and Learning Experiences
1. Apply nursing counseling principles as it relates to the care of individuals <ol style="list-style-type: none"> a) One to one relationship b) The phases of nurse-client relationship 	Chapter 28, pp 662-681 Table 28-1, pp 663 Table 28-2, pp 665 www.prenhall.com/kneisl Student CD Rom (Independent Study)

UNIT 5 : Nursing Intervention Strategies and Outcomes

CLASS 6 Group and Family Interventions

Enabling Objectives	Resources and Learning Experiences
1. Discuss how to create and maintain a group 2. Identify what strategies would be used to assess and intervene with families 3. Discuss nursing interventions that apply to groups and families	Chapter 29, pp 685-691. 695-705 Box 29-1, p 687 Figures 29-1 through Figure 29-3, p 688 Figure 29-6 www.prenhall.com/kneisl Student CD Rom (Independent Study)

UNIT 5: Nursing Intervention Strategies and Outcomes

CLASS 6 Cognitive and Behavioral Interventions

Enabling Objectives	Resources and Learning Experiences
1. Compare and contrast cognitive and behavior therapies 2. Discuss how to design a behavioral contact to promote change in health related behavior	Chapter 30,709-723 Box 30-1, p 709 Intervention- Highlights of Developing a Behavioral Contract, p 721 www.prenhall.com/kneisl Student CD Rom (Independent Study)

UNIT 5: Nursing Intervention Strategies and Outcomes

CLASS 6 Psychopharmacology

Enabling Objectives	Resources and Learning Experiences
<ol style="list-style-type: none"> 1. Explain the pharmacokinetics and pharmacodynamics of psychotropic medications 2. Assess the client taking psychiatric medications <ol style="list-style-type: none"> a) Neuroleptics b) Psychotropics c) Mood disorders d) Antidepressants e) Anxiolytic Medications 	<p>Chapter 31, pp 725-761 Box 31-2, p 728 Box 31-3, p 730 Table 31-2, p 733 Table 31-3, pp 736-737 Assessment (EPS) p 738 Client/Family Teaching, p 748 Assessment-Serotonin Syndrome, p 751</p> <p>www.prenhall.com/kneisl Student CD Rom (Independent Study)</p>

UNIT 5: Nursing Intervention Strategies and Outcomes

CLASS 6 Complementary and Alternative Healing Practices

Enabling Objectives	Resources and Learning Experiences
<ol style="list-style-type: none"> 1. Discuss complementary and alternative healing practices 2. Discuss the role of the nurse 	<p>Chapter 32, pp 765-767, 774-778</p> <p>www.prenhall.com/kneisl Student CD Rom (Independent Study)</p>

UNIT 5: Nursing Intervention Strategies and Outcomes

CLASS 6 Crisis Intervention

Enabling Objectives	Resources and Learning Experiences
<ol style="list-style-type: none"> 1. Apply nursing care to the management of clients experiencing a crisis 2. Identify the various types of crises that a person can experience 3. Apply balancing factors in the assessment of a crisis 	<p>Chapter 33, 784-801 Figure 33-2, p 785 Box 33-1 and Box 33-2, p 786 Figure 33-4, p 789 Box 33-4, p 794</p> <p>www.prenhall.com/kneisl Student CD Rom (Independent Study)</p>

UNIT 5: Nursing Intervention Strategies and Outcomes

CLASS 6 Intervening in Violence in the Psychiatric Setting

Enabling Objectives	Resources and Learning Experiences
<ol style="list-style-type: none"> 1. Recognize why a humanistic interactionist perspective is important in the comprehensive assessment of adolescent problems 2. Distinguish the various roles of the nurse in caring for adolescents in multiple settings 3. Relate nursing care of the management of adolescents with psychiatric mental health disorders 4. Describe ways to deescalate potentially violent behavior 	<p>Chapter 34, pp 807-817 Table 34-1, p 805 Assessment: Indicators of Impending Violence, p 807 Figure 34-2, pp 808-809</p> <p>www.prenhall.com/kneisl Student CD Rom (Independent Study)</p>

UNIT 5: Nursing Intervention Strategies and Outcomes

CLASS 6 Forensic Psychiatric Nursing

Enabling Objectives	Resources and Learning Experiences
<ol style="list-style-type: none"> 1. Discuss the emerging specialty of psychiatric forensic nursing 	<p>Chapter 35, pp 821-833 Box 35-1, p 822 Table 35-1, p 823 Table 35-2, p 824</p> <p>www.prenhall.com/kneisl Student CD Rom (Independent Study)</p>

**FAYETTEVILLE STATE UNIVERSITY
DEPARTMENT OF NURSING**

**SKILLS COMPETENCY PROFILE
NURS 405—Psychiatric Nursing**

SKILL	Present during discussion	Simulated In lab (dates)	Competent to perform (if applicable)	Comments
Communication Techniques a) Identify Techniques that promote effective communication b) Identify Techniques that are barriers to effective communication c) Role Play various communication techniques				
Defense Mechanism a) Define Defense Mechanisms b) Identify Defense Mechanisms c) Role Play use of Defense Mechanisms				
3. Mini Mental Status Examination (Folstein)				
Mental Status Examination				
Process Recording				

Interpersonal Process Recording (IPR)

Purpose:

To provide the student feedback related to use of therapeutic communication skills while at the same time serve as a method to increase awareness of personal values, beliefs, and feelings that might affect the nurse-patient relationship.

Directions:

Complete IPR for the first three (3) weeks of clinical, unless directed differently by clinical instructor.

Record your patient interaction on 5-10 minutes of goal-directed therapeutic communication with a patient each week. Focus should be on therapeutic use of self.

Record verbal and non-verbal responses of both student and patient to indicate process and content of interaction. (See example).

Evaluation column should include a description of the effectiveness of the student's comments:
For example:

Nurse: "Tell me what brought you to the hospital?"

Patient: "I began feeling depressed...and felt like dying."

Technique: Broad opening statement. (Then state why this technique was used)

Analysis (Evaluation): Effective because patient talked freely. It was used to help guide the conversation and allow the patient to freely discuss his situation.

Instructor may recommend additional learning experiences if deficiencies are noted.

Example of Psychiatric Interpersonal Process Recording (IPR)

Brief description of client and environment where the interaction occurred.			
<p>Patient was sitting in the dayroom. The dayroom is shaped like a rectangle. A square table is in the middle of the room. Four chairs are at the table. There were two windows in the room that had the blinds open. There was a glass window that you could see into the hallway from the dayroom. There were four other patients in the day room. Two patients were sitting at the square table and the other two patients were sitting in chairs against the wall to the right of me. The patient was sitting in a chair against the side wall appearing quiet and had a flat affect. I sat beside the patient in a chair with my back to the wall as well. The patient was sitting to the left of me and to the right of me was the door. The television was playing in the background really softly. Adequate description</p>			
Student's and Client's Verbal and Nonverbal Communication	Student's Comments (Rationale for Interaction)	Technique/Analysis (Evaluation)	Instructor's Comments
<p>Student: (I had introduced myself to the patient earlier that morning while she was in the hallway.)</p> <p>“How are you doing?”</p> <p>Patient: “Doing okay, but be better if I was out of the hospital.” (patient was smiling)</p> <p>Student: “What are you in the hospital for?”</p> <p>Patient: “I was hearing people talking in the background when I knew no one else was there.”</p>	<p>Thoughts and Feeling:</p> <p>This allows her to feel comfortable speaking to me since she had already seen me earlier.</p> <p>I wanted to see how the patient was feeling today.</p> <p>It seemed to me as if the patient was in “good spirits”.</p> <p>I wanted to see if the patient knew why she was okay now and how it differed from when she was admitted.</p> <p>I was then curious as to whether these were command hallucinations.</p>	<p>Questioning is one way of speaking to clients to see how they are feeling that day (Kneisl, Wilson, and Trigoboff, 2004). It was effective. The patient responded with further conversation.</p> <p>“Questioning controls the nature and range of the client's responses” (Kneisl, Wilson, and Trigoboff, 2004). Effective because patient talked freely.</p>	

<p>Student: “What were the people saying?”</p> <p>Patient: “I couldn’t hear what they were saying, it just sounded like mumbling.”</p> <p>Student: “Have you heard those people today?”</p> <p>Patient: “No, thank goodness” (Patient seemed relieved as evident by a small smile).</p>	<p>This helps identify the nature and possible cause of the hallucinations.</p> <p>I knew then that these were not command hallucinations.</p> <p>I knew that I needed to find out if she was still having these hallucinations or if it happened just one time.</p> <p>I felt very relieved to see that she appeared to be getting better.</p>	<p>Clarifying is an attempt to help me understand what exactly the patient is hearing (Kneisl, Wilson, and Trigoboff, 2004).</p> <p>This is still considered clarifying since I am still trying to find out more about the hallucinations. “Clarifying is an attempt to understand the basic nature of a client’s statement” (Kneisl, Wilson, and Trigoboff, 2004).</p>	
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Axis I: PTSD; Mood Disorder NOS; Amphetamine Induced Psychotic Disorder with hallucinations; Cocaine abuse; Alcohol abuse; Cannabis abuse

Axis II: Deferred

Axis III: none

Axis IV: not known

Axis V: 45

Bibliography

Kneisl, C., Wilson, H., & Trigoboff, E. (2004). E. Garofalo, & M. Meserve, Eds. *Contemporary psychiatric-mental health nursing* (pp. 142-159). Pearson Education.

EXAMPLE OF PSYCHIATRIC NURSING PLAN OF CARE

**FAYETTEVILLE STATE UNIVERSITY
DEPARTMENT OF NURSING
CLINICAL PREPARATION FORM**

Student CBB
Date August 20, 2008
Clients initials M.Z Age 35

Instructor Mrs. Banks

DIRECTIONS: Complete sections A-C prior to the start of the clinical day. Submit completed form to a clinical instructor prior to beginning of shift;

- A. Stage of Development (include theorist and behaviors indicative of achievement of developmental task. Address Piaget and Erikson for pediatrics).

M.Z is a 35 year-old Caucasian male in the middle adult hood stage. My client is experiencing stagnation, in which my client has failed to pursue intimate relationship and he has been unsuccessful in establishing a family for generational continuance.

- B. Textbook Description: (Refer to a nursing text to obtain 1-6; **NOT THE CLIENT'S KARDEX.** Use the university or hospital library when your text is insufficient).

1. Medical Diagnosis (Name primary and secondary)

Axis I- Schizoaffective disorder, Cocaine dependence, nicotine dependence

Axis II- none

Axis III- Nerve damage to left leg, history of cerebrospinal fluid leak, Degenerative back disease

Axis IV- interpersonal, social, financial, homeless

Axis V- 25

2. Etiology

Although the causes of schizoaffective disorder are unknown, it is suspected that this diagnosis represents a heterogeneous group of patients, some with atypical forms of schizophrenia and some with very severe forms of mood disorders. There is little evidence for a distinct variety of psychotic illness. It follows then that the etiology is probably identical to that of schizophrenia in some cases or to mood disorders in others (cite source)

3. Pathophysiology

Although the exact etiology of schizoaffective disorder is unknown, it may involve the balance of dopamine and serotonin in the brain. Others believe that it may be due to in utero exposure to viruses, malnutrition, or even birth complications (cite source)

4. Signs and Symptoms (Include expected changes in lab values).

People with schizoaffective disorder usually experience the following symptoms; strange or unusual thoughts or perceptions, delusion, hallucination, manic mood, irritability, thought of suicide, lack of concern about hygiene and irrelevant or incoherent speech.

- Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):
 - Delusions
 - Hallucinations

- Disorganized speech (e.g., frequent derailment or incoherence)
- Grossly disorganized or catatonic behavior
- Negative symptoms, i.e., affective flattening, alogia, or avolition

Only one symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other

5. Medical and/or Surgical Management

Treatment typically involves meeting both the physical and psychosocial needs of the patient based on the previous level of adjustment and his response to medical and nursing interventions. Antipsychotic medications are used to treat both the psychotic and affective symptoms. Group therapy, family intervention, and specific individual therapy can be helpful in terms of increasing interpersonal skills, insight into the illness and need for medication. Assistance with occupational issues can also be beneficial.

6. Nursing Management

The nurse must assess the patient's ability to carry out activities of daily living, paying special attention to his nutritional status. Monitor his weight if he isn't eating. If the client thinks his food is poisoned allow the client to fix his or her own food if possible. Maintain a safe environment, minimizing stimuli, and administer prescribed medication to decrease symptoms and anxiety.

C. Standards of Care:

Nursing DX	Goal (1) & Objectives (4)	Implementation (5)	Rationale	Evaluation
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Nursing DX	Goal (1) & Objectives (4)	Implementation (5)	Rationale	Evaluation
<p>1. Impaired social interaction related to impaired thought processes as evidenced by client verbalizing I hear voices.</p>	<p>Client will engage in one or two activities with minimal encouragement from nurse or family upon discharge.</p> <p>1. Client will engage in one activity with nurse by the end of the day.</p> <p>2. Client will attend one structured group activity within one week.</p> <p>3. Client will maintain and interaction with another client while doing an activity (drawing, playing cards)</p> <p>4. Client will use appropriate skills to initiate and maintain interaction upon discharge.</p>	<p>1. The nurse will assess if medication has reached therapeutic levels.</p> <p>2. The nurse will ensure the goals are realistic whether in the hospital or community.</p> <p>3. The nurse will keep the client in an environment as free of stimuli as possible.</p> <p>4. The nurse will spend frequent, short periods with the client.</p>	<p>1. Many of the positive symptoms (paranoia, delusions, and hallucinations) will subside with medications, which facilitate interaction. (E. Varcarolis, pg 229)</p> <p>2. Avoid pressure on client, sense of failure on part of nurse/family. The sense of failure can lead to mutual withdrawal. (E. Varcarolis, pg 229)</p> <p>3. Client might respond to noises and crowding with agitation, anxiety, and increased inability to concentrate. (E. Varcarolis, pg 229)</p> <p>4. An interested presence can provide a sense of being worthwhile. (E. Varcarolis, pg 229)</p>	<p>Goals met. The client attended two group therapies and engaged in conversation with the nurse.</p>

Nursing DX	Goal (1) & Objectives (4)	Implementation (5)	Rationale	Evaluation
<p>2. Altered thought process related to chemical alteration as evidence by inappropriate non-reality-based thinking.</p>	<p>Client will demonstrate increased ability to cope with abstinence from drug use upon discharge</p> <ol style="list-style-type: none"> 1. Client will have no self-inflicted injury while hospitalized. 2. Client will participate in treatment decisions. 3. Client will state that the thoughts are less intense and less frequent with aid of medication and nursing intervention upon discharge. 4. Client will participate in at least two groups by the end of the day. 	<ol style="list-style-type: none"> 1. The nurse will utilize safety measures to protect clients or others. 2. The nurse will help the client to identify feeling related to hallucinations. 3. The nurse will interact with the client on the basis of things in the environment. Try to distract the client from their hallucinations by engaging in reality-based activities. 4. The nurse will teach the client coping skills that minimize worrying thoughts. 	<ol style="list-style-type: none"> 1. The client may be experiencing thoughts that might dictate them to hurt others. (E. Varcarolis, pg 239) 2. Important clues to underlying fears and issues can be found in the client's seemingly illogical fantasies. (E. Varcarolis, pg 229) 3. When thinking is on reality-based activities, the client is free of hallucinations during that time. Helps focus attention externally. (E. Varcarolis, pg 229) 4. When the client is ready, teach strategies the client can do alone. (E. Varcarolis, pg 229) 	<ol style="list-style-type: none"> 1. Goal met client did not harm himself. 2. Goal met, client verbalized that group therapy treatment was not helpful to him. 3. Goal not met, client verbalized hearing voices. 4. Goal met, client attended two group therapy meetings.

Reference Page is required

Complete Mental Status Examination and History

Appearance

Record the patient's sex, age, race, and ethnic background. Document the patient's nutritional status by observing the patient's current body weight and appearance. Remember recording the exact time and date of this interview is important, especially since the mental status can change over time such as in delirium.

Recall how the patient first appeared upon entering the room for the interview. Note whether this posture has changed. Note whether the patient appears more relaxed. Record the patient's posture and motor activity. If nervousness was evident earlier, note whether the patient still seems nervous. Record notes on grooming and hygiene. Most of these documentations on appearance should be a mere transfer from mind to paper because mental notes of the actual observations were made when the patient was first encountered. Record whether the patient has maintained eye contact throughout the interview or if he or she has avoided eye contact as much as possible, scanning the room or staring at the floor or the ceiling.

Attitude toward the examiner

Next, record the patient's facial expressions and attitude toward the examiner. Note whether the patient appeared interested during the interview or, perhaps, if the patient appeared bored. Record whether the patient is hostile and defensive or friendly and cooperative. Note whether the patient seems guarded and whether the patient seems relaxed with the interview process or seems uncomfortable. This part of the examination is based solely on observations made by the health care professional.

Mood

The mood of the patient is defined as "sustained emotion that the patient is experiencing." Ask questions such as "How do you feel most days?" to trigger a response. Helpful answers include those that specifically describe the patient's mood, such as "depressed," "anxious," "good," and "tired." Elicited responses that are less helpful in determining a patient's mood adequately include "OK," "rough," and "don't know." These responses require further questioning for clarification.

Establishing accurate information pertaining to the length of a particular mood, if the mood has been reactive or not, and if the mood has been stable or unstable also is helpful.

Affect

A patient's affect is defined in the following terms: expansive (contagious), euthymic (normal), constricted (limited variation), blunted (minimal variation), and flat (no variation). A patient whose mood could be defined as expansive may be so cheerful and full of laughter that it is difficult to refrain from smiling while conducting the interview. A patient's affect is determined by the observations made by the interviewer during the course of the interview.

Speech

Document information on all aspects of the patient's speech, including quality, quantity, rate, and volume of speech during the interview. Paying attention to patients' responses to determine how to rate their speech is important. Some things to keep in mind during the interview are whether patients raise their

voice when responding, whether the replies to questions are one-word answers or elaborative, and how fast or slow they are speaking.

Thought process

Record the patient's thought process information. The process of thoughts can be described with the following terms: looseness of association (irrelevance), flight of ideas (change topics), racing (rapid thoughts), tangential (departure from topic with no return), circumstantial (being vague, ie, "beating around the bush"), word salad (nonsensical responses, ie, jabberwocky), derailment (extreme irrelevance), neologism (creating new words), clanging (rhyming words), punning (talking in riddles), thought blocking (speech is halted), and poverty (limited content).

Throughout the interview, very specific questions will be asked regarding the patient's history. Note whether the patient responds directly to the questions. For example, when asking for a date, note whether the response given is about the patient's favorite color. Document whether the patient deviates from the subject at hand and has to be guided back to the topic more than once. Take all of these things in to account when documenting the patient's thought process.

Thought content

To determine whether or not a patient is experiencing hallucinations, ask some of the following questions. "Do you hear voices when no one else is around?" "Can you see things that no one else can see?" "Do you have other unexplained sensations such as smells, sounds, or feelings?"

Importantly, always ask about command-type hallucinations and inquire what the patient will do in response to these commanding hallucinations. For example, ask "When the voices tell you do something, do you obey their instructions or ignore them?" Types of hallucinations include auditory (hearing things), visual (seeing things), gustatory (tasting things), tactile (feeling sensations), and olfactory (smelling things).

To determine if a patient is having delusions, ask some of the following questions. "Do you have any thoughts that other people think are strange?" "Do you have any special powers or abilities?" "Does the television or radio give you special messages?" Types of delusions include grandiose (delusions of grandeur), religious (delusions of special status with God), persecution (belief that someone wants to cause them harm), erotomanic (belief that someone famous is in love with them), jealousy (belief that everyone wants what they have), thought insertion (belief that someone is putting ideas or thoughts into their mind), and ideas of reference (belief that everything refers to them).

Aspects of thought content are as follows:

- **Obsession and compulsions:** Ask the following questions to determine if a patient has any obsessions or compulsions. "Are you afraid of dirt?" "Do you wash your hands often or count things over and over?" "Do you perform specific acts to reduce certain thoughts?" Signs of ritualistic type behaviors should be explored further to determine the severity of the obsession or compulsion.
- **Phobias:** Determine if patients have any fears that cause them to avoid certain situations. The following are some possible questions to ask. "Do you have any fears, including fear of animals, needles, heights, snakes, public speaking, or crowds?"
- **Suicidal ideation or intent:** Inquiring about suicidal ideation at each visit is always important. In addition, the interviewer should inquire about past acts of self-harm or violence. Ask the

following types of questions when determining suicidal ideation or intent. "Do you have any thoughts of wanting to harm or kill yourself?" "Do you have any thoughts that you would be better off dead?" If the reply is positive for these thoughts, inquire about specific plans, suicide notes, family history (anniversary reaction), and impulse control. Also, ask how the patient views suicide to determine if a suicidal gesture or act is ego-syntonic or ego-dystonic. Next, determine if the patient will contract for safety. For homicidal ideation, make similar inquiries.

- Homicidal ideation or intent: Inquiring about homicidal ideation or intent during each patient interview also is important. Ask the following types of questions to help determine homicidal ideation or intent. "Do you have any thoughts of wanting to hurt anyone?" "Do you have any feelings or thoughts that you wish someone were dead?" If the reply to one of these questions is positive, ask the patient if he or she has any specific plans to injure someone and how he or she plans to control these feelings if they occur again.
- Sensorium and cognition: Perform the Folstein Mini-Mental State Examination.
- Consciousness: Levels of consciousness are determined by the interviewer and are rated as (1) coma, characterized by unresponsiveness; (2) stuporous, characterized by response to pain; (3) lethargic, characterized by drowsiness; and (4) alert, characterized by full awareness.
- Orientation: To elicit responses concerning orientation, ask the patient questions, as follows. "What is your full name?" (ie, person). "Do you know where you are?" (ie, place). "What is the month, date, year, day of the week, and time?" (ie, time). "Do you know why you are here?" (ie, situation).
- Concentration and attention: Ask the patient to subtract 7 from 100, then to repeat the task from that response. This is known as "serial 7s." Next, ask the patient to spell the word "world" forward and backward.
- Reading and writing: Ask the patient to write a simple sentence (noun/verb). Then, ask patient to read a sentence (eg, "Close your eyes."). This part of the MSE evaluates the patient's ability to sequence.
- Visuospatial ability: Have the patient draw interlocking pentagons in order to determine constructional apraxia.
- Memory: To evaluate a patient's memory, have them respond to the following prompts. "What was the name of your first grade teacher?" (ie, for remote memory). "What did you eat for dinner last night?" (ie, for recent memory). "Repeat these 3 words: 'pen,' 'chair,' 'flag.'" (ie, for immediate memory). Tell the patient to remember these words. Then, after 5 minutes, have the patient repeat the words.
- Abstract thought: Assess the patient's ability to determine similarities. Ask the patient how 2 items are alike. For example, an apple and an orange (good response is "fruit"; poor response is "round"), a fly and a tree (good response is "alive"; poor response is "nothing"), or a train and a car (good response is "modes of transportation"). Assess the patient's ability to understand proverbs. Ask the patient the meaning of certain proverbial phrases. Examples include the following. "A bird in the hand is worth 2 in the bush" (good response is "be grateful for what you already have"; poor response is "one bird in the hand"). "Don't cry over spilled milk" (good response is "don't get upset over the little things"; poor response is "spilling milk is bad").
- General fund of knowledge: Test the patient's knowledge by asking a question such as, "How many nickels are in \$1.15?" or asking the patient to list the last 5 presidents of the United States or to list 5 major US cities. Obviously, a higher number of correct answers is better; however, the interviewer always should take into consideration the patient's educational background and other training in evaluating answers and assigning scores.
- Intelligence: Based on the information provided by the patient throughout the interview, estimate the patient's intelligence quotient (ie, below average, average, above average).

Insight

Assess the patients' understanding of the illness. To assess patients' insight to their illness, the interviewer may ask patients if they need help or if they believe their feelings or conditions are normal.

Judgment

Estimate the patient's judgment based on the history or on an imaginary scenario. To elicit responses that evaluate a patient's judgment adequately, ask the following question. "What would you do if you smelled smoke in a crowded theater?" (good response is "call 911" or "get help"; poor response is "do nothing" or "light a cigarette").

Impulsivity

Estimate the degree of the patient's impulse control. Ask the patient about doing things without thinking or planning. Ask about hobbies such as coin collecting, golf, skydiving, or rock climbing.

Reliability

Estimate the patient's reliability. Determine if the patient seems reliable, unreliable, or if it is difficult to determine. This determination requires collateral information of an accurate assessment, diagnosis, and treatment.

MSE written summary (example)**Mental Status Assessment Summary**


25 year old African American Female admitted to the unit on 4/21/07 with a diagnosis of major depression. Patient admitting complaint was " I feel sad". According to patient, she graduated from high school, is employed, and lives with her husband and two children. She states she has no religious preference. She has no known allergies to food or medicine. She states she is not on any special diet. She admits to only sleeping 2-3 hours per night for the past few weeks. Her husband brought her to the Emergency Department because she tried to kill herself by slitting her wrist.

She is alert and oriented X4. She has poor eye contact throughout the interview. Her posture was slouched and her clothes looked disheveled. She appears her stated age and weight. During the interview she sat in the chair with her eyes downcast. Her speech was a slow rate, monotone volume and hesitant rhythm when answering questions. She was cooperative with the interviewer. Her mood was depressed; affect is congruent with her mood.

She denies any perceptual disturbances or thought disorders. She denies homicidal ideations however she states that she is currently experiencing suicidal thoughts with a plan to slit her wrists. She has agreed to contract with interviewer for safety. Recent memory is intact. Remote memory is intact. Abstract thinking is impaired. She has good impulse control when angry. Judgment is good and insight is fair

Mini Mental Status Examination

The "Mini" Mental Status Exam is a quick way to evaluate cognitive function. It is often used to screen for dementia or monitor its progression.

Folstein Mini Mental Status Examination			
Task	Instructions	Scoring	
Date Orientation	"Tell me the date?" Ask for omitted items	One point each for year, season, date, day of week, and month	5
Place Orientation	"Where are you?" Ask for omitted items.	One point each for state, county, town, building, and floor or room	5
Register 3 Objects	Name three objects slowly and clearly. Ask the patient to repeat them.	One point for each item correctly repeated	3
Serial Sevens	Ask the patient to count backwards from 100 by 7. Stop after five answers. (Or ask them to spell "world" backwards.)	One point for each correct answer (or letter)	5
Recall 3 Objects	Ask the patient to recall the objects mentioned above.	One point for each item correctly remembered	3
Naming	Point to your watch and ask the patient "what is this?" Repeat with a pencil.	One point for each correct answer	2
Repeating a Phrase	Ask the patient to say "no ifs, ands, or buts."	One point if successful on first try	1
Verbal Commands	Give the patient a plain piece of paper and say "Take this paper in your right hand, fold it in half, and put it on the floor."	One point for each correct action	3
Written Commands	Show the patient a piece of paper with "CLOSE YOUR EYES" printed on it.	One point if the patient's eyes close	1
Writing	Ask the patient to write a sentence.	One point if sentence has a subject, a verb, and makes sense	1
Drawing	 <p>Ask the patient to copy a pair of intersecting pentagons onto a piece of paper.</p>	One point if the figure has ten corners and two intersecting lines	1

Scoring

A score of 24 or above is considered normal.

30