CHAPTER 3

The Psychiatric Nursing Assessment

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LEARNING OBJECTIVES

After reading this chapter, you will be able to:

- Identify the components of a holistic assessment, including mental status examination.
- Correctly use psychiatric terminology to describe a client's symptoms.
- Choose the appropriate interviewing techniques to gather information for a holistic assessment.
- Demonstrate an understanding of the role of psychological testing, including rating scales, in assessment.
- Demonstrate understanding of each of the five axes in a *DSM-IV-TR* diagnosis.

KEY TERMS

Affect
Biopsychosocial history
Chief complaint
Closed-ended questions
Collateral history
Concrete thought process
Coping skills
Countertransference
Delusions
Differential diagnosis
Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., text revision *(DSM-IV-TR)
Empathy
Global assessment of functioning scale
Hallucinations
History of present illness (HPI)
Holistic psychiatric assessment
Homicidal thoughts
Impulse control
Insight
Judgment
Mental status examination
Mood
Multiaxial *DSM-IV-TR* diagnosis
Open-ended questions
Physical assessment
Psychiatric nursing interview
Psychological tests
Resistance
Self-disclosure
Suicidal thoughts
Therapeutic contract
Transference

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Introduction

The evaluation of psychiatric clients is a multifaceted endeavor, most effectively performed by an interdisciplinary team of mental health professionals. A comprehensive, **holistic psychiatric assessment** examines the physical, psychological, intellectual, social, and spiritual aspects of the individual. The **physical assessment** may include a physical examination, a study of the client's biologic life stage and genetic predisposition, laboratory tests, and diagnostic tests such as magnetic resonance imaging (MRI) and electroencephalography (EEG). The psychological evaluation surveys childhood experiences, personality, and current objective and subjective symptoms of psychiatric illness. This information is gathered by interviewing the client and family, by performing a **mental status examination**, and by administering specific **psychological tests** and rating scales. Cognitive functioning is best assessed by utilizing a standard measure such as the Mini-Mental State Examination. The social assessment consists of an exploration of cultural, environmental, and familial influences on the expression and experience of illness, and the spiritual assessment is an exploration of the client's religious and spiritual dimensions (**Table 3-1**).

The psychiatric nursing evaluation covers the assessment, diagnosis, outcome identification, and planning stages of the nursing process. The evaluation is ongoing; as more of the client's history and new **insights** into his or her issues come to light, the diagnosis and treatment plan evolve accordingly.

Assessment

The ability to assess clients is one of the psychiatric nurse's most important skills. The assessment process defines the client's problem and allows

Table 3-1 Holistic Psychiatric Nursing Assessment

Assessment Tool	Component Parts	Dimension Addressed
Biopsychosocial history	Chief complaint	Psychological
	History of present illness	Psychological
	Psychiatric history	Psychological
	Alcohol and substance use history	Psychological
	Medical history	Physical
	Family history	Psychological, physical, social
	Developmental history	Psychological, physical, social
	Social history	Social
	Occupational/educational history	Social
	Culture	Social
	Spirituality	Spiritual
	Coping skills	Psychological
Mental status examination	Behavior and appearance	Psychological, physical, social
	Emotions: mood and affect	Psychological
	Speech	Psychological, physical, social, intellectual
	Thought process and content	Psychological, social, intellectual, spiritual
	Perceptual disturbances	Psychological, physical
	Impulse control	Psychological, physical
	Cognition and sensorium	Intellectual, physical
	Knowledge, insight, and judgment	Intellectual, psychological
Psychological tests	Multiple tools, including rating scales	Psychological, intellectual
Physical assessment	Physical examination	Physical
	Assessment of activities of daily living	Physical
	Laboratory tests	Physical
	CT scans/other diagnostic tests	Physical

the nurse and client to establish a relationship. A thorough nursing assessment is a prerequisite for formulating an appropriate nursing diagnosis and plan of care. Assessment data also provide a baseline level of functioning that is used to evaluate, change, and respond to the treatment plan.

Data used for assessment are gathered not only from the client, but also from other sources. The client's self-assessment usually differs from the perception of family, coworkers, other clients in the hospital, and members of the treatment team; those views also vary between groups. Additionally, anyone's perception of the client will change over time.

Assessment guidelines vary according to the specific dimensions of the client being evaluated; however, the need for a structured interview and a data collection tool is widely accepted. Tools and guidelines for performing comprehensive nursing assessments assist in evaluating clients, improve the nurse's professional image, and increase job satisfaction (Catherman, 1990). Lengthy assessment tools are often met with resistance by staff nurses who struggle with time constraints in the workplace (Schreiber, 1991). This resistance is partially justified by shorter stays in the hospital, increased client acuity, and financial pressure to decrease the nurse-to-client ratio throughout the healthcare system.

Nurses must narrow the range of their data collection to the information judged most relevant. It is the quality and not the quantity of the assessment data that matters (Regan-Kubinski, 1995). The following guidelines for a holistic psychiatric nursing assessment should be tailored to meet the specific needs of the nurse, client, and situation. These guidelines provide instructions for conducting a **psychiatric nursing interview** to obtain data for a **biopsychosocial history** and mental status examination.

Psychiatric Nursing Interview

An interview is a conversation with a deliberate purpose that ideally is mutually accepted by the participants. It differs from a social conversation in that one participant (the nurse) is responsible for the content and flow of the interaction, while the other participant (the client) is the focus of the discussion. The interview must take place within a specific time frame. The purpose of the psychiatric nursing interview is to gather the information necessary to understand and treat the client.

The content and process of the interview vary according to the state of the participants and the context in which the interview takes place. For example, an agitated client has just been admitted to an acute psychiatric unit of a teaching hospital. The client's severe impairment, the nurse's need to budget time, and the busy nature of the setting indicate that a series of brief, structured interviews is the most viable approach. The members of the interdisciplinary treatment team (psychiatrist, nurse, social worker, and other specialists) share the responsibility for data collection. With consent, family or significant others may be approached to elucidate the client's story. The content of the initial interview should focus on eliciting information to help the staff provide a safe environment for the client and others (i.e., the client's potential for suicidal and violent behavior is assessed).

The content of the psychiatric nursing interview focuses on the client's biopsychosocial history and current mental status.

Content of the Psychiatric Nursing Interview: Biopsychosocial History

Biopsychosocial history is a comprehensive assessment of the client's lifetime biologic, psychological, and social functioning.

Assessment guidelines and data collection tools should be individualized for each client during the psychiatric evaluation.

Identifying Data

A written biopsychosocial history begins with a succinct summary of the client's demographics: name, age, gender, marital status, ethnicity, religion, occupation, education, and current living situation.

The chief complaint and HPI provide valuable data for psychiatric and medical clients.

Chief Complaint

The client's **chief complaint** is the reason for current contact with the mental health system. The chief complaint should be obtained in the client's own words. Because of the nature of the illness, the client's statement may differ greatly from the family's or evaluator's assessment of the situation (e.g., an in-patient insists that she is in the hospital for a medical checkup following her abduction by aliens). The chief complaint provides valuable data concerning the client's illness.

History of Present Illness

The **history of present illness (HPI)** is a chronologic account of the events leading up to the current contact with the mental health professional.

The HPI includes a description of the evolution of the client's symptoms that covers the onset, duration, and change of symptoms over time. Exacerbating and ameliorating factors of the current psychological distress must be explored, and the nurse should delineate factors that may have precipitated the current episode. These stressful events may be negative (e.g., job loss) or positive (e.g., job promotion). Attendant changes in somatic functioning (sleep pattern, appetite, cognitive ability, sexual functioning) should also be noted. This information is similar to that obtained when clients are evaluated for nonpsychiatric medical illnesses (see **Table 3-2**).

Psychiatric History

Information concerning past psychiatric illness must be obtained to understand the current episode, to make an accurate diagnosis, and to make a prognosis. Psychiatric illness may be a single event, chronic, or intermittent, and the course of the illness may improve or deteriorate over time.

Alcohol and Substance Use History

Studies have shown high co-morbidity of mental illness and alcohol or substance abuse. Causality is difficult to discern, because alcohol and drug abuse may precipitate an episode of mental illness or may represent a client's attempt to cope with a preexisting mental disorder. Research has shown that drug and alcohol use in the mentally ill adversely affects the course of their illness (Sadock, Kaplan, & Sadock, 2003).

The nurse should obtain a history of the client's caffeine and nicotine use; both are prevalent in psychiatric clients. Caffeine may supply energy to depressed and schizophrenic clients; caffeine and caffeine withdrawal may cause agitation as well. Nicotine use may increase attention span and memory in clients with schizophrenia but may decrease the efficacy of neuroleptics. Nicotine withdrawal may lead to agitation or depression (American Psychiatric Association [APA], 2000; Rauter, de Nesnera, & Grandfield, 1997).

Medical History

The nurse should ascertain significant illnesses, injuries, and treatments received. The client must be assessed for allergies and past and present side effects from medication. An Abnormal Involuntary Movement Scale (AIMS; Guy, 1976) examination may be done to measure psychotropic medication–induced motor side effects. In performing an AIMS examination, the nurse observes for abnormal muscle movement while the client performs a series of simple motor tasks. Women should be questioned concerning

Table 3-2 Comparison of Assessment for Physical and Mental Disorders

	Chief Complaint	
	Angina	**Depression**
Quality	"Chest tightening, with pain radiating down my left arm."	"Emotional pain that feels like I am going to die."
Severity	"Severe—a 9 on a scale of 1 to 10."	"Severe—a 9 on a scale of 1 to 10."
Timing	"It lasts about 5 minutes."	"It is constant."
	History of Present Illness	
	Angina	**Depression**
Factors that aggravate	Exercise, emotional stress, and meals	Stress at work, arguments with family members, and morning hours
Factors that alleviate	Rest and nitroglycerine tabs	Social contact, activities, and antidepressant medication
Associated symptoms	Dyspnea, nausea, and sweating	Anhedonia (chronic inability to experience pleasure), diminished appetite, and insomnia
Chronology	Started with chest pain on exertion 1 year ago; getting increasingly more severe and frequent	Started with a sad mood and feeling overwhelmed after a job promotion 6 months ago; getting increasingly more incapacitating and unrelated to life events over time

their menstrual cycles, pregnancies, and menopause; hormonal changes may have a significant impact on the client's mental health. The nurse should evaluate the client's risk for falling and skin breakdown and take note of assistive devices the client requires (e.g., eyeglasses, hearing aides, dentures, canes, walkers).

Family History

Families are no longer blamed for causing mental illness; rather, they are taught about the condition and engaged in the treatment process. Obtaining a family history of mental illness is important, because many of these disorders are hereditary. Bipolar and unipolar mood disorders, schizophrenia, and attention deficit disorder (ADD) have significant genetic components. The client's response to specific interventions may be inherited as well, and should be included in the family history (Sadock et al., 2003).

Developmental History

The developmental history is an account of the client's infancy, childhood, and adolescence. It may provide clues to the origin of current behaviors and aid in the diagnosis. Erikson (1963) created a developmental timetable to identify the psychosocial adaptation required during each stage of life. All stages, beginning with birth and extending through senescence, are characterized by developmental tasks. The successful completion of these tasks, crucial to both happiness and success with subsequent tasks, represents optimal adaptation at a given stage. In contrast, failure at these tasks may lead to difficulty completing future tasks and may stifle psychosocial growth. Self-esteem, self-control, and independence emerge during toddlerhood, peak during the industry versus inferiority stage (6 years of age through puberty), and represent key issues in assessing an adult's ability to cope with the stress of illness, for example (see **Table 3-3**).

Childhood mental disorders, temperament, and style of interpersonal relationships may remain with the client into adulthood. Additionally, psychic trauma (e.g., neglect or abuse, loss of parent) experienced by a client during childhood may adversely affect brain development, leading to **impulse control** problems, personality disorder, posttraumatic stress disorder (PTSD), depression, or other psychiatric illness (Terr, 1991). It is estimated that 25% of children under age 16 will experience some kind of trauma (National Child Traumatic Stress Network, 2004). Data show that 34–53% of the mentally ill population report childhood sexual or physical abuse, with a 29–43% rate of PTSD among the seriously mentally ill (Kessler et al., 1995).

Clinical Example

Jerry is a 34-year-old male diagnosed with chronic paranoid schizophrenia, brought to the hospital by the police after threatening to harm passersby on the street. Jerry became enraged when he discovered that the hospital was a smoke-free environment; he had been smoking one to two packs of cigarettes per day for 15 years. Jerry was offered treatment with a nicotine patch or gum; however, he adamantly refused this treatment. Jerry required physical restraint on one occasion and medication on several other occasions, due to psychotic agitation that was exacerbated by nicotine withdrawal. Jerry was stabilized on psychotropic medications and was discharged within 2 weeks. Upon discharge, Jerry resumed smoking and had a relapse of psychotic symptoms. His psychiatrist attributed the outpatient decompensation to the diminished efficacy of the antipsychotic medication, because the medication dose had been titrated in the hospital while Jerry was nicotine-free. Jerry's condition was stabilized with an increase in dose.

A high level of *comorbidity* exists between mental illness and alcohol or substance abuse, and there is evidence that both may have a genetic or familial component.

Social History

A client's ability to make and sustain relationships indicates the ability to utilize the therapeutic relationship and aids in the diagnosis. Larger social networks are correlated with decreased severity of mental illness and a more thorough recovery. It is often difficult to ascertain whether a client's social problems have precipitated or resulted from the mental illness.

The psychiatric nurse should inquire about the client's family and household members. How have family and significant others responded to the client's illness? Often, a family member's mental illness is extremely disruptive to the family system (Terkelson, 1987). Seek the client's permission to involve family members and significant others in the assessment and treatment process, unless this involvement would be counterproductive. Ascertain a history of the client's friendships and sexual partners.

The nurse should have the client describe these relationships or lack thereof. Is the client satisfied with his or her social role at this point in life? For example, some persons become distressed when they fail to accomplish social milestones such as marriage by a certain age. Assess the client's wider social network, including religious organizations, community centers, and clubs. The client's living situation is also integral to the assessment, because many of the client's stressors

Table 3-3 Erikson's Stages of Psychosocial Growth and Development

Age Group	Developmental Stage Task	Characteristics
Infancy	Trust vs. mistrust	The goal is the development of a sense of trust. Consistent attention to physical needs within a reasonable time period builds trust.
Toddlerhood	Autonomy vs. shame and doubt	The goal is the achievement of autonomy. An environment in which the child is able to explore surroundings in a safe way engenders autonomy. Successful toilet-training plays a key role.
Preschool age	Initiative vs. guilt	The goal is the development of a sense that the child's actions produce outcomes through opportunity to try to do things on one's own.
School age	Industry vs. inferiority	The goal is a feeling of self-worth, gained by mastering schoolwork, sports, and other competitive activities.
Adolescence	Identity vs. role confusion	The goal is to establish a unique identity, first by rejecting adults and identifying with peer group and later by developing individuality.
Young adulthood	Intimacy vs. isolation	Establishment of close relationships with members of both sexes.
Middle adulthood	Generativity vs. stagnation	The goal is a feeling of giving back to the younger generation or society, through successfully adjusting to changing roles in marriage, parenting, and career.
Late adulthood	Integrity vs. despair	The goals are to attain a sense of continuity of past, present, and future, of meaning in one's life as it was, and of acceptance of death. This is achieved through life review and reminiscence.

are environmental in origin. Homelessness, for example, is a severe social stressor (see **Figure 3-1**).

Occupational and Educational History

It is essential to establish a client's past and present level of function in work and school. A sporadic or chaotic employment history may indicate personality disorder or frequent episodes of mental decompensation. Work- or school-related stress may have precipitated the illness. Assess the impact that hospitalization or treatment may have on the client's function at work or school. The client's level of education partially determines how the nurse can most effectively communicate with and educate the client. Low socioeconomic status has been correlated with a relatively high rate of symptoms of mental illness (Gresenz, Sturm, & Tang, 2001).

Figure 3-1 Homelessness is a severe social stressor.

Culture

Ethnicity, race, social class, degree of acculturation, and language should be included in the cultural assessment. Culture can significantly influence the development, expression, and reporting of mental disorders; thereby affecting diagnosis. A clinician who is unfamiliar with the nuances of an individual's culture may see psychopathology when a behavior or experience may actually be a normal variation of the client's culture, such as a Native American who hears a dead relative's voice while grieving. Some symptom clusters are uniquely associated with certain cultures, such as an "ataque de nervios" (nervous attack) in the Hispanic population (APA, 2000). In clients with depression, biological symptoms (e.g., sleep and appetite disturbances) may tend to be universal, whereas psychological symptoms have been shown to vary by culture. Members of certain groups may be more likely to present with somatic complaints. Culture-specific rating scales may therefore be

helpful in assessing clients from diverse backgrounds (Kinzie & Manson, 1987).

Culturally competent assessment also requires sensitivity to the process of assessment. The client's comfort level in regard to disclosing private issues with unfamiliar people, having physical closeness with unfamiliar people, involving family in the assessment process, and being addressed by first name varies among age, socioeconomic, and ethnic groups. Because of a history of negative experiences that certain groups such as Native Americans have had with mainstream medicine, members of these groups may be reluctant to participate in the traditional Western assessment or treatment process (Vedantam, 2005). The presence of language barriers must be carefully assessed, because clients who may appear to speak English adequately may be more comfortable in their native tongue, especially when discussing emotional issues. Ideally, interpreters are familiar with medical terminology and are not members of the client's own family (to decrease communication problems and protect the client's privacy).

The efficacy of different treatment modalities and beliefs regarding the etiology and treatment of mental illness may also vary among cultures and must be considered when developing a treatment plan. Among some people in certain cultures, mental illness may be viewed as a punishment for past wrong-doing or as a result of a curse; convincing clients with these beliefs that Western medication will treat the illness can be challenging. Enlisting the help of community elders or traditional healers, instead of arguing against the beliefs, may be helpful in this regard (Vedantam, 2005). The role of the extended family and community in assisting with the treatment of the mentally ill also differs among groups, which will also need to be considered when delineating care. In some cultures, the mentally ill tend to be ostracized whereas in others the community takes pride in caring for these individuals. Even the efficacy, dosing, and side effects of psychotropic medication may differ significantly among ethnic groups (Vedantam, 2005).

Although it is important to have a working knowledge of general differences among cultures, it is essential that the nurse avoid stereotyping individual clients on the basis of ethnic, racial, or social group membership. Data supporting that African Americans and whites presenting with comparable symptoms are diagnosed with different mental illnesses (with the African Americans more likely diagnosed with pervasive illnesses such as schizophrenia) point to continued prejudices within our healthcare system (Blow, Zeber, McCarthy, Valenstein, Gillon, & Bingham, 2004; Neighbors, Trierweiler, Ford, & Muroff, 2003). The first step toward culturally sensitive practice is healthcare workers' examination of their prejudices regarding other cultures and the effect that their own culture has on their work.

The psychiatric nurse must consider the client's culture without stereotyping the client.

Spirituality and Values

Spirituality is an often neglected aspect of assessment, especially in the acute care setting. Nursing as a profession may have overlooked the spiritual aspects of assessment and care as it has struggled to assert itself as a research-based profession (Govier, 2000). However, a client's lack of or sense of spirituality may have a tremendous impact on illness and treatment. The belief in a divine plan and a benevolent God is comforting to many clients (Carson & Arnold, 1996). Some clients feel that spirituality decreases their sense of aloneness and despair. Spirituality and religiosity may deter suicide and violence. Conversely, some clients may become angry with God for having caused their suffering and may lose faith. Spiritual aspects of treatment, such as the concept of a higher power in the 12-step treatment program for alcohol and drug abuse, may engage spiritually minded clients but deter those who are not religious. A diagnostic category of religious or spiritual problems has been included in the **Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR)** (APA, 2000).

Religion is a way of expressing spirituality through an organized framework and through rituals. Clients should be asked about religion and whether or not they would like clergy involved in their treatment. Religiosity is correlated with relatively high levels of social support, decreased rates of depression, high levels of cooperation, and high levels of cognitive functioning (Koenig, 2007; Koenig, George, & Titus, 2004). In adolescents, religiosity is correlated with lower levels of drug abuse, violence, and behavioral problems (Barnes, Plotnikoff, Fox, & Pendelton, 2000).

We often equate religion with spirituality; however, spirituality is a much broader concept. Although atheists do not believe in God and agnostics are unsure of God's existence, it cannot be assumed that spirituality is absent in members of

Spirituality is a much broader concept than religion; it includes sources of motivation and strength, and finding meaning and connectedness to one's self, others, the environment, and a higher power.

these groups. Govier (2000) did an extensive literature search and determined that an exploration of reason, reflection, relationships, and restoration were other important components of spirituality that should be assessed. Reason and reflection refer to the client's sources of motivation and strength, and the client's ability to take time to reflect on the meaning of his or her life or situation. Relationships refer to the client's sense of connectedness to others and to the environment. Restoration refers to the ability of the spiritual dimension to positively influence the physical aspect of care. On the other hand, spiritual distress (which can be the outcome of certain adverse life events) can precipitate or aggravate a course of illness.

Nurses who are not in touch with their own spirituality will tend to shy away from including an in-depth spiritual assessment of clients, so self-awareness is the first step toward performing a competent spiritual assessment. Observing for the presence of a bible, cross, or star of David may also give clues to the client's spirituality. Being present with the client, using active listening skills, being nonjudgmental, and taking care not to impose one's personal beliefs onto the client are essential skills in addressing a client's spiritual side.

Critical Thinking Questions What kinds of challenges would you expect when working with a client whose cultural or spiritual background differs from yours? What would you do to overcome potential difficulties?

Coping Skills

A client's past coping style may help identify useful strategies to cope with the present illness.

Coping skills are mechanisms people use to manage internal and external stressors. Coping behaviors can enable an individual to alter a stressful situation by controlling, or at least minimizing, the stress resulting from the situation. Clients with chronic psychiatric or life-threatening medical illness may be unable to alter their condition, but can attempt to control the stress and minimize its effect on their lives. A client in this situation may reveal several behavioral signs. They may seek more information about their illness and treatment options. These clients may participate in self-care and reach out to others, including healthcare professionals, family members, and friends. They may also attend support groups and express their feelings about self-concept, body image, and physical function. They may practice deep breathing relaxation exercises.

Conversely, maladaptive coping mechanisms are behaviors that ultimately interfere with the client's ability to confront the stressor, may be harmful, and usually produce additional stress. Unfortunately, they are "tried and true" mechanisms; the client has successfully used them in the past to maintain emotional stability in the short-term. Consequently, clients tend to rely on these coping mechanisms to deal with future stressors. Such behaviors include alcohol and drug abuse, overeating, inappropriate anger, and social withdrawal.

Discerning the client's characteristic pattern of coping—whether it is adaptive or maladaptive—helps the nurse to predict how the client may react during a current stressor. It is often helpful to spend time uncovering and encouraging the use of the adaptive coping mechanisms that have been successfully used by the client in the past, because clients in current crisis are often feeling overwhelmed and may need prompting to remember the skills in their arsenal.

Content of the Psychiatric Nursing Interview: Mental Status Examination

Whereas the biopsychosocial history is a record of the client's entire lifetime, the mental status examination is an evaluation of the client's present state. Behavior and general appearance, **mood** and **affect**, speech, thought process and content, perceptual disturbances, impulse control, cognition, knowledge, **judgment**, and insight are assessed. Although it is termed an "examination," this assessment guideline requires little direct questioning beyond what is required for taking a biopsychosocial history; most pertinent information is gleaned from the interview process and content.

The acronym BEST PICK is a helpful way to remember the composition of the mental status examination:
Behavior and general appearance
Emotions: mood and affect
Speech
Thought content and process
Perceptual disturbances
Impulse control
Cognition and sensorium
Knowledge, insight, and judgment

The acronym BEST PICK can assist in the recall of the main elements of the mental status examination: **B**ehavior and general appearance; **E**motions: mood and affect; **S**peech; **T**hought content and process; **P**erceptual disturbances; **I**mpulse control; **C**ognition and sensorium; and **K**nowledge, insight, and judgment.

Behavior and General Appearance

Note the client's body frame, posture, dress, grooming, and age-appropriateness of appearance. Some common adjectives used to describe the client's general appearance include *disheveled*, *well-groomed*, *heavily made-up*, *younger* or *older looking than biologic age*, *tensely postured*, *under-* or *overweight*, and *casually dressed*.

In terms of behavior, assess the client's gait, activity level, gestures, mannerisms, and psychomotor activity. Manic clients may be agitated and unable to sit still, whereas clients with schizophrenia may exhibit bizarre postures or psychomotor retardation. Observe for the rare symptoms of echopraxia (a mimicking of the interviewer's behavior), catatonia (statue-like immobility), and waxy flexibility (when limbs can be moved by the interviewer into positions that the client then maintains). Attempt to differentiate between movement disturbances secondary to mental illness and those resulting from medication side effects. Some antipsychotic medications may cause akathisia (motor restlessness), dystonia (stiffness), or dyskinesia (involuntary muscle movement).

The psychiatric nurse should always evaluate how the client relates to the interviewer and to the interviewing process. Is the client cooperative or uncooperative, bored, angry, or flirtatious?

Emotions: Mood and Affect

The client's mood is the pervasive subjective emotional state, and the visible expression of this state is termed the *affect*. Observe the depth, range, and fluctuation of emotional expression during the interview. Ask the client directly about his or her mood if the information is not offered spontaneously. Both mood and affect can be described as *euthymic* (normal), *labile* (rapidly changing from one mood state to another), *depressed*, *irritable*, *anxious*, *angry*, *euphoric* (excessively happy), *frightened*, or *empty*. Variability in the client's affect should be noted, ranging from *flat* (no variability) to *labile* (rapid fluctuation in affect). It is important to note congruity or incongruity of mood and affect. For example, some depressed clients look depressed, whereas others who are depressed appear euthymic.

Speech

The psychiatric nurse must observe the rate, amount, style, and tone of speech the client uses during the interview. Speech may range from pressured to hesitant, loud to inaudible, spontaneous to nonspontaneous, slurred to clear, and monotonous to dramatic. The client may be described as talkative or taciturn, depending upon the quantity of speech. Observe for evidence of dysarthria (physical difficulty in vocalizing), echolalia (the repetition of the interviewer's words), perseveration (the repetition of the same words or themes), aphasia (difficulties in understanding or producing speech), and other disorders or oddities of speech.

A *euthymic mood* is a normal mood. A *labile mood* is one that changes rapidly from one state to another. A *euphoric mood* is an excessively happy one.

Dysarthria is a physical difficulty in vocalizing. *Echolalia* is the repetition of the interviewer's words. *Perseveration* is the repetition of the same words or themes. *Aphasia* includes problems in understanding or producing speech.

Thought Content

The psychiatric nurse should note any abnormalities in the client's thought content. *Obsessions* are intrusive thoughts or ideas that the client recognizes as "crazy" but acts in accordance with anyway (e.g., compulsive hand washing from an obsessive fear of germs). Hypochondriasis is an obsession with physical concerns that do not exist in reality.

Delusions are convictions that have no basis in reality. Delusions may be *paranoid*, *grandiose*, *somatic* (involving bodily concerns), *erotic*, *nihilistic* (involving death or destruction), *guilty*, *bizarre*, or *referential* (believing that benign environmental occurrences relate to or have special meaning for the client). The degree of congruence between the client's mood and the type of delusion experienced should be noted. Delusional content is occasionally revealed spontaneously during the psychiatric interview. For example, a client may ask the nurse to help him to hide from a Mafia hit man. Conversely, the nurse should be aware that a paranoid client may be guarded in his or her discussion of delusions secondary to pervasive lack of trust. In most cases, clients have little insight that their thoughts are delusional, and do not label them as such. The validity of delusions should not be questioned by the interviewer; such questioning is ineffective in changing the client's beliefs and often causes alienation and anger (Sadock et al., 2003).

Assessment of suicidal and homicidal thoughts is a priority in all evaluations of thought content. **Suicidal thoughts** are the client's desires to kill or harm him- or herself, and *homicidal thoughts* are the client's desires to kill or harm

Referential delusions (ideas of reference) are false beliefs that things in the environment relate to the client or have special meaning for the client.

Clinical Example

Laura is a 26-year-old female hospitalized with an acute exacerbation of chronic paranoid schizophrenia. After the clients watched a televised news segment about Jerusalem, Laura was overheard discussing with the other clients her need to go on a pilgrimage to Jerusalem. Laura verbalized that one particular newscaster was speaking directly to her during the show, which is how she knew that she needed to go there. After Laura was accidentally bumped into by her hospital roommate later that day, Laura told her nurse that she then realized that the roommate was determined to join her in the pilgrimage. The nurse recognized these interchanges as referential delusions, active symptoms of Laura's schizophrenia.

A detailed account of the client's suicidal and homicidal thoughts must be obtained through direct questioning.

others. Contrary to popular belief, discussing these feelings with a client does not increase, and may lower, the likelihood of the client's acting on them. Direct questioning is essential. Questions regarding suicidal and **homicidal thoughts** should elicit information regarding the client's exact plan (including method, extent of lethality of method, availability of the means to carry out the plan), motivation or desire to carry out the plan, steps already taken to complete the plan, and factors preventing the client from following through, such as religiosity. The presence of active suicidal or homicidal thoughts constitutes a psychiatric emergency, and immediate action to ensure the safety of the client or the object of the client's anger is necessary.

Thought Process

The *thought process* is the way in which the client thinks. It is often evinced in the client's speech. Loose associations are marked by an illogical, difficult-to-follow shifting of ideas. Tangential thinking is exhibited when the client wanders from the subject at hand to a related one and is unable to come back to the original topic. Loose associations, tangential thought, word salad (completely nonsensical combination of words), and neologisms (nonsensical string of sounds that are formed into made-up words) often indicate schizophrenic disorders.

Circumstantial thought is demonstrated by clients who get lost in details but eventually return to the relevant topic. *Thought blocking* occurs when the thinking process stops altogether and the mind goes "blank." *Flight of ideas*, as seen in mania, involves pressured speech with rapid topic changes; the topics may be associated, but in a strange way. For example, "I can see! The sea is washing away the shells." *Confabulation,* often indicating dementia, is a fabrication of information to fill in for memory gaps. For example, a client may give an elaborate but untrue story about how he or she spent the day.

A client with a **concrete thought process** as opposed to an *abstract thought process* is only able to understand conversations literally. For example, a client who is asked what brought him or her to the hospital and responds, "an ambulance," is manifesting concrete thinking. A client's ability to think abstractly may be ascertained by assessing the client's interpretation of a proverb such as "people in glass houses should not throw stones" or the client's ability to describe similarities between objects such as a chair and table. Concrete thought is common in clients with schizophrenic disorders. A concrete thought process is not pathological when exhibited by children, however, who developmentally may not have the capacity for abstract thought until early adolescence (Sadock et al., 2003).

Perceptual Disturbances

Illusions, which are common in delirium, are misinterpretations of true stimuli. An example is when a curtain in a dark room is mistaken for a person. **Hallucinations** are defined as sensations experienced by the client without real external stimuli. A patient may not have intact reality testing, the ability to accept evidence that these perceptions are not real. Clients who appear to be talking to imaginary others or pointing at nonexistent objects during the assessment are probably experiencing hallucinations or illusions. Direct questioning regarding perceptual disturbances is usually required to elicit the specific symptoms. Hallucinations may be auditory, visual, gustatory, olfactory, or tactile; clients may hear, see, taste, smell, or feel things that in reality do not exist. Auditory hallucinations are the most common type; the more unusual visual, gustatory, olfactory, and tactile hallucinations may indicate medical illness or substance intoxication or withdrawal.

Hypnagogic and hypnopompic hallucinations are false sensory perceptions that occur while falling asleep and while awakening from sleep, respectively. Depersonalization is a perceptual difficulty in which the client feels unreal, dead, or mechanical; derealization is the sensation that the outside world is unreal. Hypnagogic and hypnopompic hallucinations, derealization, and depersonalization are considered within the normal range of experience and are not considered pathologic unless they cause undue distress or problems with daily functioning.

Impulse Control

Impulse control is the ability to delay, modulate, or inhibit the expression of behaviors and feelings. Clues to the client's ability to control his or her impulses are found in the content and process of the general interview. A client who describes a recent history of binge drinking and indiscriminate sexual contacts has poor impulse control. A person who storms out of an interview when difficult topics are broached also evinces poor impulse control. Assessing the client's ability

to control impulses is an integral part of determining potential for acting on suicidal and violent thoughts.

Cognition and Sensorium

Level of consciousness, orientation, concentration, and memory are especially important to determine when assessing clients with coexisting medical problems or those who reveal symptoms of dementia during the interview. During the psychiatric interview, clients provide many clues to their sensorium. A client with an altered level of consciousness during the interview demonstrates a fluctuating ability to maintain awareness of the environment. Orientation is assessed by simply asking the client additional questions regarding full name, current location, date, and time.

A client's memory and concentration are determined by the ability to answer questions regarding psychiatric history. Concentration may also be assessed by asking the client to count backward from 100 by 7s (100, 93, 86 . . .), and memory is tested by asking the client to remember three objects immediately and to recall them after 5 minutes. Be aware that clients may have impairments in remote, recent past, recent, and immediate memory. The Mini-Mental State Examination (MMSE) efficiently and objectively measures cognition (Folstein, Folstein, & McHugh, 1975). The psychiatrist, psychologist, or advanced practice nurse typically performs this examination.

The client's intellectual functioning (below average, average, superior) may be estimated from the interview process as well.

Knowledge, Insight, and Judgment

Knowledge, insight, and judgment are related concepts usually ascertained while taking the client's history and while observing and discussing the client's actions in social situations and in dealing with mental illness. *Judgment* is the capacity to identify possible courses of action, anticipate their consequences, and choose the appropriate behavior. *Insight* refers to the extent of the client's awareness of illness and maladaptive behaviors. A client who tells the interviewer of reuniting with a physically abusive spouse because she feels that the spouse will change demonstrates poor judgment and little insight. A client who is admitted to the hospital for the third time because of noncompliance with antipsychotic medication, and who states that he stopped taking the medication because he is not really mentally ill, lacks knowledge of and insight into his illness and demonstrates poor judgment in regard to treatment. A client's judgment may be assessed by evaluating the answer to a hypothetical question such as: "What would you do if you found a stamped, addressed envelope in the street?"

Critical Thinking Questions What kind of information gathered in the mental status examination would prompt you to take immediate action? Specifically, what action would you take?

The Process of the Psychiatric Nursing Interview

The psychiatric nurse must pay attention to both the content of the client's words and the process of communication. How the client interacts with the nurse and the behaviors the client exhibits during the interview often provide important information concerning the client's symptomatology and ability to relate to others.

Empathy is the ability to put oneself in someone else's place. The nurse who can empathize with a client is able to understand how the client feels in a particular situation.

The interviewing process varies, ranging from casually talking with clients while, at the same time, assisting them with activities of daily living, to utilizing a standardized rating scale. Different methods may yield different information.

Phases of the Interview

An interview consists of a beginning, middle, and termination phase. In the initial moments of the interview, the nurse should begin to develop a rapport with the client and to engage the client in the meeting. Establishing a good rapport with a client is not simple; the nurse must put the client at ease, empathize with the client's suffering (i.e., understand how the client feels in a particular situation by mentally putting oneself in the client's place), listen compassionately, become the client's ally, and instill trust in the client of the nurse's expertise. The nurse must clarify the purpose of the meeting, which is to gain an understanding of the client's problems and to determine the best way to help. The client should be informed about the healthcare setting and the interviewer's credentials, and the rules of confidentiality should be discussed; these are requisite to making the client feel comfortable enough to share information.

During the middle phase of the interview, data are collected and processed. The nurse obtains information from and gives information to the client. For example, the nurse may assist the client in identifying ways to cope with symptoms.

The termination phase of the interview summarizes what has been accomplished during the meeting. A tentative diagnosis and an initial care plan are formulated and shared with the client. The termination phase is also used to help the client relax from the often emotional interaction (Kadushin, 1997).

Interviewing Techniques

One of the most important interviewing skills is the ability to be silent and attentive. Nonverbal communication, such as nodding in understanding and leaning slightly toward the client, demonstrates caring and attentiveness. Encouraging words, such as "I see" or "go on," enable the nurse to gather information without bombarding the client with questions. Allowing the client to discuss the chief complaint during the first few minutes of the interview is often an effective strategy to induce the client to "open up." Paraphrasing or summarizing the content and feelings related during the interview demonstrates that the nurse understands what the client has said and helps both the interviewer and the client to process an abundance of information. The nurse may need to ask questions for clarification to avoid jumping to conclusions about nebulous communications. Gentle transition statements such as, "What you are telling me about is important; however, there is one more important thing that we still need to discuss," keeps the interview on track without offending the client. Interviewing techniques must be individualized to the client's specific problems and personality (**Table 3-4**).

Self-Disclosure

Revealing personal information about oneself is a controversial technique that requires nursing experience, insight, and sophistication on the part of the interviewer. The nurse should share personal information with a client only if, after careful evaluation, the nurse believes that this sharing would benefit the client and improve treatment. The nurse should never disclose personal information for selfish reasons.

Self-disclosure is a controversial intervention that should only be used to benefit the client and the therapeutic process, never for selfish reasons.

Clinical Example

A client is going through a bad breakup of a relationship. The nurse may feel tempted to tell the client of a similar experience (e.g., "I know how you feel. My boyfriend and I just split up."). The nurse may feel good revealing this; however, a client in acute distress may feel that the nurse is not understanding his or her unique feelings and circumstances.

Additionally, **self-disclosure** reverses the interviewer-client dynamic and severs the client from the role of information-giver. One unique issue of self-disclosure involves the health professional who divulges a personal history of mental illness. In this situation, as in others, the nurse should discuss with an experienced nurse or supervisor and be guided by what best serves the client's interests.

One piece of information important to disclose to the client to protect the client's rights is the interviewer's name, title, and position. Many students and beginning practitioners are reluctant to divulge their novice status. Clients, however, may pick up on an interviewer's newness. Thus, denying that you are new in the field may cause a lack of trust. Clients who seem distressed by the nurse's lack of experience should be encouraged to discuss this with the nurse and may be referred to the nurse's supervisor for reassurance if necessary. Psychiatric clients who have had previous experience with new nurses and students often come to expect this as the norm; certain clients actually take pride in "training" new nurses.

Critical Thinking Questions What kind of personal information would be appropriate to share with a nonpsychotic client on the first interview? How and in what context would you disclose this information?

Choosing Appropriate Questions

The client's state and the subject being evaluated determine whether to ask open-ended or **closed-ended questions**. **Open-ended questions** are vague and may be answered in many different ways. The nurse may say, "Tell me about your problem." Open-ended questions are most helpful in obtaining a broad range of information from clients without thought disorders. *Closed-ended questions* elicit specific and concise information. Disorganized clients who are unable to tolerate a long interview usually need to be guided by closed-ended questions when giving information. Some topics of discussion, such as suicidal thoughts, lend themselves to direct questioning; clients who are given more freedom to answer may skirt the issue or provide incomplete information. Questions typically become more specific or closed-ended as the interview progresses (Sadock et al., 2003).

Certain types of questions should be avoided when evaluating the client, because they may taint the information elicited. Leading questions such as, "You do not abuse street drugs, do

Table 3-4 Therapeutic Versus Nontherapeutic Interviewing Techniques

Goal	Therapeutic Techniques and Examples	Nontherapeutic Techniques and Examples
To engage the client in treatment	Offering self: "I will stay here with you for a while." Suggested collaboration: "Let's work together to see if we can identify when your problems began."	Giving false reassurance: "Don't worry; everything will be fine." Using platitudes: "Keep your chin up; tomorrow is another day."
To get the client to open up and share information	Judiciously using silence. Actively listening by nodding and leaning toward the client. Using encouraging verbalizations such as "yes" and "I understand." Offering general leads such as "please continue" or "I am interested in hearing more about that."	Asking questions that yield only "yes" or "no" answers. Asking incessant closed-ended questions, so that the conversation seems like an interrogation.
To convey to the client that you understand	Summarizing the content. Restating content: *Client:* "I am so depressed that I cannot even eat." *Nurse:* "So your depression has caused you to lose your appetite." Reflecting on process: "You seem anxious." "It seems difficult for you to talk about this."	Using premature interpretations that deny the client's feelings: "You're not really angry with your mother; you're just looking for attention." Inappropriately using self-disclosure: "I know just how you feel, because my boyfriend just broke up with me, too."
To get the client more actively involved in treatment	Reflecting client's questions back to him or her: *Client:* "What should I tell people at work about my hospitalization?" *Nurse:* "What are you thinking about telling them?" Encouraging comparison: "What have you done in the past when faced with such a difficult situation?" Encouraging decision making: "What will you do the next time that you find yourself in a similar situation?"	Overtly agreeing or disagreeing with the client: "What you did was definitely the right (or wrong) thing to do." Giving advice: "I think that you should . . ."
To explore a topic in more detail	Exploring: "Could you tell me more about that issue?" Focusing: "Let's go back and discuss that topic further."	Bombarding the client with multiple closed-ended questions on a topic.
To diffuse a client's nonpsychotic anger	Agreeing with the grain of truth in the client's complaint: *Client:* "I hate this hospital. It's like a jail." *Nurse:* "I can see how you would feel that way, with all of the rules and the locked door. Let's talk about how you can be more comfortable here."	Denying the client's reality: *Client:* "I hate this hospital. It's like a jail." *Nurse:* "You know that this is not a jail."
To help the client control aggressive behavior	Limit-setting: "I will not be able to continue to talk with you if you continue to act in a threatening manner." Giving positive reinforcement for calm behavior. Decreasing stimuli: Placing the client in a quiet area until he or she is calmer.	Punishing the client: "You are going to have to stay in your room for 1 hour because you cursed at me" (choosing an arbitrary time period, unrelated to the client's behavior).
To clarify information	Asking for clarification: "Could you explain that to me again?" "Let's see if I have this straight." Placing events in sequence: "Did you start to drink alcohol before or after becoming depressed?"	Jumping to conclusions about the meaning of a client's statement, instead of seeking clarification.
To determine causes of problems or behaviors	Nonjudgmentally exploring: "What is it that gets in the way of your getting up to make it to work on time?"	Asking confrontational "why" questions: "Why are you unable to get to work on time?"

continues

Table 3-4 Therapeutic Versus Nontherapeutic Interviewing Techniques, continued

Goal	Therapeutic Techniques and Examples	Nontherapeutic Techniques and Examples
To effectively address delusional content	Focusing on the feeling content of delusions: *Client:* "People are trying to kill me!" *Nurse:* "You must be very frightened."	Directly challenging a client's belief system: *Client:* "Laser beams are irradiating me!" *Nurse:* "There is no way that laser beams are being sent through you—that's impossible."
To move to another topic of discussion	Transitioning gently: "What you are saying is very important, and I want to give it proper attention when we have more time. Right now, however, we need to move on."	Rejecting a client's topic or abruptly changing the subject: "It's not necessary to go into that right now. Let's talk about your hallucinations instead."

you?" steer the client to answer in a certain way. Questions beginning with *why* may make the client become defensive. For example, "Why did you not follow your physician's instructions and take your medication?" is more confrontational than "Tell me more about your decision to stop taking medication." Questions leading to yes or no answers such as, "Do you drink alcohol?" may yield incomplete data, as opposed to an open-ended question, such as, "Describe your alcohol use."

Client-Related Factors Influencing the Interview

A client may provide unreliable information during the interview for several reasons. Symptoms of mental illness such as delusions, disorganized thought, or disorganized speech may interfere with communication and alter the client's sense of reality. The client's lack of insight may also lead to an altered perception of reality. For example, an alcoholic may tell the nurse that he or she only drinks "socially." Some clients may purposely distort or provide false information (e.g., an undocumented alien who feigns citizenship or a client with antisocial personality disorder who denies a criminal history). A client who is poorly motivated for treatment (e.g., an involuntary client) often resists giving information.

Clinician-Related Factors Influencing the Interview

The nurse's interviewing skills are based on experience, intuition, critical-thinking ability, personality, and communication style.

The nurse's level of skill affects the flow of the interview and the information obtained. Interviewing skills are related to the nurse's degree of psychiatric experience, use of intuition or "gut feeling," critical thinking abilities, personality, and communication style. The nurse's ability to convey acceptance and **empathy** helps the client to feel comfortable in sharing information that is of a sensitive nature. The nurse's interest and enthusiasm may help the client to overlook small interviewing errors and inexperience (Sadock et al., 2003). The nurse's ability to be genuine is also important, because clients usually sense when others are acting unlike their true personalities. For example, the nurse should not attempt to bond with an inner-city adolescent by using unfamiliar slang.

The nurse's culture, race, age, religion, gender, socioeconomic status, and intellect necessarily affect the interview process. A nurse must not avoid issues that are important to the client but that are difficult for the nurse because of personal background. For example, a nurse for whom spirituality is unimportant must not ignore the client's spirituality.

Transference

Transference is traditionally defined as a client's unrealistic and often inappropriate feelings, thoughts, and behaviors toward the therapist. Transference in this traditional sense is an unconscious displacement of attitudes originally held toward other significant persons in the client's life, especially from early childhood, onto the healthcare professional (Goldstein, 1995). The concept of transference includes an appreciation for the role that the reality of the therapeutic relationship plays in determining the client's response to treatment and attitude toward the healthcare worker. For example, a minority client who has been the victim of prejudice may be appropriately apprehensive about disclosing information to a therapist with the same ethnic background as his or her oppressors.

Depending upon the client, the mental health professional, and the specific relationship between the two, the client's reactions toward the professional comprise degrees of reality and fantasy. Reality reactions are more likely to occur with healthier clients whereas unconscious transference from displacement of prior relationships predominantly occurs in psychotic clients. Nurses who actively participate in the interview process correlate with more reality-based transference, because clients see these nurses as real people rather than blank screens onto which fantasies may be projected (Goldstein, 1995).

Countertransference

The healthcare professional's feelings and reactions toward the client are known as **countertransference**. Countertransference can be viewed similarly on a reality-fantasy continuum. Woods and Hollis (2000) believe that workers displace feelings, attitudes, and fantasies onto some clients more than others, depending on the workers' particular life experiences.

Vannicelli (1992) has identified the following indicators of the presence of countertransference: inappropriate emotional responses toward the client, feelings of exhaustion, stereotyped or fixed responses regardless of what the client is saying, exaggerated emotional responses, impulses to treat the client in a special way, and extreme over- or underinvolvement. Education, supervision, and consultation with colleagues are essential for the nurse to use the countertransference productively. Appropriately analyzed, countertransference may offer important clues to a client's diagnosis or symptoms. For example, a nurse's feelings of extreme anger during an interview may identify the client's hidden rage.

Power Disparity

One important source of transference and countertransference is the power disparity between the interview participants. The interviewer (the nurse) assumes the responsibility for moving the interaction forward to achieve a goal, while the client passively answers questions. This situation often results in a transference, which for the client represents a repetition of feelings and reactions from past experiences with authority figures. Depending upon the client's history and current symptoms, the client may be overly compliant with the interviewer (e.g., tell the interviewer exactly what the interviewer wants to hear) or overly oppositional (e.g., assert that the professional has "no right" to ask such personal questions). For the nurse, the power disparity may cause feelings of omnipotence and fantasies of being able to "save" the client. The nurse may fail to involve the client in the treatment plan and may feel anger toward noncompliant clients as well.

Transference consists of realistic and unrealistic feelings that the client has toward the mental health professional. *Countertransference* are the feelings the worker has toward the client.

Resistance

Resistance refers to anything that impedes the progress of the interview or treatment. A client's resistance is often self-protective, and in many cases reticence increases when the client is confronted directly. During the initial interview, the client genuinely may be too paranoid, disorganized, despondent, or agitated to respond to all the questions. Confronting this resistance by asking the client why he or she is not being "up-front" with the interviewer may cause the client to retreat further. Temporarily changing the subject when a client becomes extremely angry or upset may enable the client to continue with the interview. Validating the client's feelings that underlie the resistance often effectively encourages the client to speak. For example, a reluctant client is more likely to self-disclose if the nurse agrees that it must be scary to trust a virtual stranger with personal information.

Interview Duration

The duration of the evaluation interview depends on the purpose of the evaluation, the client's state, and the nurse's availability. The

Clinical Example

Leo is a 15-year-old male admitted to a residential treatment center for the treatment of oppositional defiant disorder. Immediately upon his arrival to the unit, the admitting nurse sat down with Leo to complete a four-page nursing assessment form. When the rest of the residents lined up to go to the cafeteria for dinner, Leo promptly got up to join them. The nurse shouted at Leo to sit back down because the assessment was not yet complete and he had not asked for permission to join the group. Leo cursed at the nurse and stated that he was hungry. The nurse shouted back to Leo that she—and not Leo—was in charge of the unit, and that if he "kept it up" she would ban him from the cafeteria for the rest of the week. The supervisor arrived at the scene and quickly recognized that a power struggle had developed between the nurse and the new resident, who were demonstrating countertransference and transference (respectively). The supervisor asked another nurse to go over the rule book with Leo and to inform him that food would soon be brought to the unit for him, while the supervisor discussed the problematic transaction privately with the admitting nurse.

interview should be relatively brief (10 to 15 minutes) if the client is acutely ill and unable to tolerate much contact and exploration. The interview may be spread out over several short interactions, and the nurse may need to sit on the floor or even stand if the client's state requires it. Focused evaluations, such as those evaluating a client for entry into an incest survivor group, are usually shorter than a broad evaluation interview because of the limited content. If an interview is abbreviated as a result of the nurse's workload, the nurse must return at a later time or delegate further interviewing tasks to a colleague.

Environmental Issues

Uncomfortable furniture, air temperature, and interruptions such as a ringing phone or beeper may impair the flow of an interview. A peaceful and comfortable environment enhances the interviewing process. The interview environment should be private enough so that confidentiality is not compromised. At the same time, the environment in which the interview takes place should also ensure the nurse's safety; leaving the door ajar and positioning oneself near the door of the room will usually conserve privacy while allowing for safe egress should a client become aggressive. Many settings have safety measures such as emergency buzzers and overhead paging systems by which other workers can be called in to assist in a crisis situation.

Collateral History

If a client is deemed an unreliable historian, additional history should be obtained from family, friends, colleagues, and mental health professionals who have had previous contact with the client; this **collateral history** may be obtained only with the client's consent, unless it is an emergency. Those accompanying the client to the evaluation interview should be interviewed at that time, if possible. The client may feel more or less comfortable being interviewed simultaneously with a significant other, and the nurse should follow the client's lead. Clients should also be allowed time alone with the interviewer; this gives them privacy to disclose important information they may not be willing to discuss in the presence of others.

With the client's consent, a *collateral history* may be obtained from family, friends, colleagues, or mental health professionals to ensure an accurate account of the client's history.

Psychological Testing

Standardized rating scales provide objective data to supplement information obtained through the nurse-client interview.

Psychological testing involves evaluation tools that objectively measure personality, intelligence, or symptomatology of specific mental illnesses. *Neuropsychological testing* is useful in detecting subtle cognitive defects in clients who are not obviously demented or brain-damaged. Psychological and neuropsychological tests are usually performed by experts in the field or specially trained nurses/mental health professionals. At minimum, nurses should be sufficiently familiar with the different tests to be able to glean meaningful information about a client from reading the testing reports. Nurses must know enough to be able to recommend that certain tests be performed.

Increasingly, nurses utilize standardized rating scales such as those used during the assessment process. Rating scales that are administered by trained healthcare professionals provide objective baseline data of a client's symptoms that can be compared to later scores to evaluate the efficacy of treatment. This is important given the current emphasis on quality assessment, cost-effectiveness, and managed care. Despite the trend toward using standardized tools for data collection, this mode of assessment cannot substitute for the nurse-client interview.

Some rating scales were designed for clients, and not professionals, to complete. Certain self-rating scales such as the Beck Depression Inventory yield reliable and valid data that can assist professionals in the diagnosis of mental illness or to gauge treatment progress. Other self-rating systems are less precise but are useful for the client's self-monitoring of illness symptoms and coping skills. A nurse and his or her client can even design their own rating scale for the client based on the client's specific illness symptoms, for use in relapse prevention. See **Table 3-5** for commonly performed psychological tests, including rating scales.

Physical Assessment

The term *mental disorder* implies a distinction between mental and physical disorders. In actuality, there is much "physical" in "mental" and much "mental" in "physical" disorders (APA, 2000). Some clients who present primarily with psychiatric symptoms may be suffering from an underlying medical illness, such as hypothyroidism or acute intermittent porphyria. As the population ages, more cases of acquired immunodeficiency syndrome (AIDS) appear, and as the incidences of substance abuse and polypharmacy increase, mental disorders resulting from general medical conditions have become more prevalent. The

Table 3-5 Commonly Performed Psychological Tests and Rating Scales

Name of Test	Purpose of Test	Description of Test
Wechsler Adult Intelligence Scale (WAIS)	Intelligence test	This test includes six verbal and five performance subtests, yielding a verbal intelligence quotient (IQ), a performance IQ, and a full-scale IQ. It is the most widely used IQ test.
Minnesota Multiphasic Personality Inventory (MMPI)	Personality assessment	This is a self-report inventory of over 500 yes or no questions, the results of which are scores on 10 different scales (e.g., depression scale, paranoia scale). The pattern of scores is interpreted by the tester by comparing the scores and subscores against standardized data.
Rorschach Test	Projective personality assessment	Clients are shown inkblots and asked to describe what they see. Clients project their needs, fantasies, and thoughts into the inkblots because of their ambiguity. This test is very difficult to analyze.
Substance Abuse Subtle Screening Inventory (SASSI)	To identify people who have a high probability of substance use disorders, even when they are unlikely to admit to the problem outright. There is one version of the test for adults, and another for adolescents.	A 15-minute questionnaire, including face valid items as well as subtle items that do not address substance misuse in a direct or apparent manner.
Abnormal Involuntary Movement Scale (AIMS)	To test for psychomotor side effects of psychotropic medication	A 12-item inventory performed by trained evaluators who rate the client's involuntary muscular movements on a scale of 0 to 4.
Hamilton Depression Rating Scale (HAM-D)	To test for severity of depression in clients already diagnosed with an affective disorder	A 21- or 17-item inventory performed by trained evaluators who rate physical and psychological symptoms of depression on a scale of 0 to 4.
Beck Depression Inventory (BDI)	To measure attitude and symptoms that are characteristic of depression	A 21-item inventory performed either by a trained professional *or* by the client, who rates depressive symptoms and attitudes on a scale of 0 to 3.
Brief Psychiatric Rating Scale (BPRS)	To assess psychopathology in clients with, or suspected of having, schizophrenia or other psychotic illness	A 16-item inventory of a broad range of psychiatric symptoms, scored by a trained professional using a 7-point Likert scale.
Mini-Mental State Examination (MMSE)	To screen for cognitive impairment caused by dementia	A nine-item structured clinician-rated interview scale incorporating pencil-and-paper tasks.

term *organic* is used in clinical practice to refer to these illnesses.

A medical workup may be completed to rule out organic illness. The medical workup also ensures that the client is well enough to tolerate psychopharmacologic and other psychiatric treatments safely. The physical examination is an essential part of the workup that may be performed by the advanced practice nurse. Basic-level nurses assess the client's vital signs, teach the client about the examination, and reassure him or her throughout the examination. Important clinical laboratory tests include serum and urine

Clinical Example

Kay, a 52-year-old woman, was admitted to the psychiatric unit from the emergency room. She presented primarily with agitation. She seemed to be hallucinating, speaking to people who were not there. On closer examination, Kay was delirious with waxing and waning cognitive abilities. She was disoriented to place and time, tachycardic, and diaphoretic. Kay was able to provide a history of hypothyroidism, which had been treated sporadically with thyroid replacement hormone. Her family provided additional history concerning Kay's chronic alcoholism. Kay was transferred to a medical unit where she was placed on a librium alcohol detoxification protocol, and her thyroid level was stabilized. Most of her presenting symptoms resolved.

The *medical workup* consists of a physical examination, clinical laboratory tests, and specialized diagnostic procedures.

drug screens; thyroid, liver, and kidney function tests; complete blood counts; and sexually transmitted disease screening. Serum tests are also used to evaluate the levels of psychotropic medications in the client's blood. A low lithium level, for example, may precipitate a manic episode. A number of medical illnesses present with psychiatric symptoms, and specific diagnostic tests are used to detect them (**Table 3-6**).

Specialized diagnostic procedures performed on psychiatric clients include an EEG, which discerns if a seizure-like basis for an illness, such as an impulse control disorder, exists. In delirium, as a result of metabolic problems, the EEG generally shows high-voltage, slow-wave activity. Other tests including MRI, computed tomography (CT), and positron emission tomography (PET) identify space-occupying lesions and metabolic brain disorders. The tests may also identify biologic markers of mental illness; researchers have found evidence of increased brain ventricle size detected by MRI and CT and decreased frontal cortex activity detected by PET in clients with certain forms of schizophrenia (Sadock et al., 2003).

Organizing Data: Diagnosis

Formulating the client's diagnosis is an integral part of the psychiatric evaluation. During the assessment, the nurse must keep an open mind and avoid settling on a definitive diagnosis early in the interview. All aspects of the holistic assessment must be considered.

All registered nurses are licensed to diagnose and treat human response to actual or potential health problems.

Nursing Diagnosis

The American Nurses Association (ANA, 2007) states that nurses diagnose "human responses to actual or potential health problems." The practice of nurses diagnosing clients has met with long-standing resistance. Many nurses who graduated prior to the inclusion of the nursing diagnosis in the college curricula feel that making a diagnosis is beyond their scope. Nurses who were exposed to the theoretical aspects of the nursing diagnosis in school often have difficulty translating this knowledge into practice. Other professionals, notably physicians, may fear that boundaries are being crossed when nurses formulate diagnoses. Clients may be wary when nurses take a leadership role in their treatment.

Nursing diagnoses were originally categorized by the North American Nursing Diagnosis Association (NANDA) in 1986, and were last revised for 2007–2008 (www.nanda.org). Nursing diagnoses may relate to actual problems, risks for problems, or wellness issues. A nursing diagnosis is a concisely worded statement that includes the diagnostic label/definition, related factors, and defining characteristics.

One example of a nursing diagnosis is "post-trauma syndrome related to physical abuse, as evidenced by flashbacks, nightmares, and hypervigilence."

Formulating nursing diagnoses is difficult because of the array of possible human responses and the causes of these responses (Regan-Kubinski, 1995). Prioritizing these diagnoses is therefore essential. Without question, safety issues must be of primary concern (e.g., the risk for self-directed violence). Some diagnoses are addressed immediately, and others require long-term intervention. Remember that several diagnoses may be addressed simultaneously and that they will continue to be addressed in the outpatient setting (e.g., with home care, day program, psychotherapy, psychopharmacology). The client and family should actively participate in prioritizing the nursing diagnoses.

Diagnostic and Statistical Manual of Mental Disorders

The *Diagnostic and Statistical Manual of Mental Disorders* has been the primary resource used throughout the United States for classifying mental disorders since its original publication in 1952. More than 1,000 health professionals analyzed scientific data and performed field trials to test for validity and reliability of diagnostic categories, to prepare the *DSM-IV* (APA, 1994). In 2000, the American Psychiatric Association revised parts of the text portion of the *DSM-IV* to include new research information regarding associated features; culture, age, and gender features; prevalence; course; and familial pattern of many of the mental disorders listed. This new version, *DSM-IV-TR*, included very few changes to the diagnostic categories; the most notable changes in this regard were with the tic disorders and the paraphilias, which may now be diagnosed even if the associated behaviors do not cause the person distress or impaired functioning (APA, 2000).

Table 3-6 Physical Illnesses Presenting with Psychiatric Symptoms

Physical Illness	Physical Symptoms	Psychiatric Symptoms	Tests Used to Diagnose Physical Illness
Acquired immunodeficiency syndrome (AIDS)	Fever, weight loss, ataxia, incontinence, seizures, and opportunistic infections	Progressive dementia, personality changes, and depression	HIV antibody test, CT scan, MRI, lumbar puncture, and blood cultures
Acute intermittent porphyria	Abdominal pain, fever, nausea, vomiting, constipation, peripheral neuropathy, and paralysis	Depression, agitation, paranoia, and visual hallucinations	CBC, pulse, and Δ-aminolevulinic acid and porphobilinogen levels
Brain neoplasm	Headache, vomiting, papilledema, and local finding on neurological examination	Personality changes	Lumbar puncture, skull x-ray, CT scan, and EEG
Hepatic encephalopathy	Hyperreflexia, ecchymosis, liver enlargement, and ataxia	Euphoria, disinhibition, psychosis, depression	LFTs, serum albumin level, and EEG
Huntington's disease	Rigidity and choreoathetoid movements	Depression and euphoria	Genetic testing
Hyperglycemia	Polyuria, anorexia, nausea, vomiting, dehydration, abdominal complaints, acetone on breath, and seizures	Anxiety, agitation, and delirium	Fingerstick for blood glucose and urine dipstick for glucose and ketones
Hyperthyroidism	Sweating, diarrhea, weight loss, tachycardia, tremor, palpitations, vomiting, and heat intolerance	Nervousness, irritability, pressured speech, insomnia, and psychosis	TFTs and ECG
Hypoglycemia	Sweating, drowsiness, stupor, coma, tachycardia, tremor, restlessness, and seizures	Anxiety, confusion, and agitation	Pulse rate and fingerstick for blood glucose
Hyponatremia	Excessive thirst, polydipsia, stupor, and coma	Confusion, lethargy, and personality changes	Serum electrolytes
Hypothyroidism	Dry skin, cold intolerance, constipation, weight gain, and goiter	Lethargy, depression, personality changes, and psychosis	TFTs and ECG
Multiple sclerosis	Sudden transient motor and sensory disturbances	Anxiety, euphoria, mania, and personality changes	Lumbar puncture and head CT
Seizure disorder	Sensory distortions and aura	Confusion, psychosis, dissociative states, catatonia-like states, violence, and bizarre behavior	EEG
Systemic lupus erythematosus	Fever, photosensitivity, butterfly rash, headache, and joint pain	Depression, mood changes, and psychosis	ANA, lupus erythematosus test, CBC, chest x-ray
Tertiary syphilis	Skin lesions, arthritis, respiratory distress, and progressive cardiovascular disease	Personality changes, decreased performance of activities of daily living, irritability, confusion, and psychosis	VDRL and lumbar puncture
Thiamine deficiency	Neuropathy, cardiomyopathy, nystagmus, and headache	Confusion and confabulation	Thiamine level
Vitamin B_{12} deficiency	Pallor, dizziness, peripheral neuropathy, and ataxia	Irritability, inattentiveness, and psychosis	Vitamin B_{12} level, Schilling test, and CBC

Note: HIV = human immunodeficiency virus; CT = computed tomography; MRI = magnetic resonance imaging; CBC = complete blood count; EEG = electroencephalogram; LFTs = liver function tests; TFTs = thyroid function tests; ECG = electrocardiograph; ANA = antinuclear antibody test; VDRL = venereal disease research laboratory test

Psychiatric nurses must be well versed in the classification system and terminology used in the *DSM-IV-TR*, but only the advanced practice registered nurse (APRN) may use the guide to diagnose a mental disorder. To diagnose a client with the *DSM-IV-TR*, an individual must have appropriate training and experience with the system (APA, 2000).

When working with the *DSM-IV-TR*, the nurse must remember that normal reactions to stressful events, such as the death of a loved one, are not considered mental disorders. Additionally, some phenomena, which in the mainstream would indicate a mental disorder, are not symptomatic for a mental disorder if they are culturally appropriate. For example, in certain Hispanic cultures persons may talk to their dead mother's ghost. Socially unacceptable behavior, such as crime, does not necessarily indicate a mental illness. Lastly, the nurse must remember that the person's diagnosis is being classified, not the person him- or herself; the client is not just a "schizophrenic," but a multifaceted individual who happens to have schizophrenia (APA, 2000).

Multiaxial *DSM-IV* Diagnosis

Diagnosing mental disorders with the *DSM-IV-TR* is not foolproof; various mental disorders have overlapping symptoms, and individuals with the same disorder may differ significantly. The manual provides text and decision-tree diagrams that assist in establishing the **differential diagnosis**. The *DSM-IV-TR* also provides guidance to diagnose clients with insufficient information or information that does not fit neatly into one category. A diagnosis may be deferred, declared provisional, or delineated as atypical or not otherwise specified (NOS; APA, 2000). The diagnostic categories of the *DSM-IV-TR* often include several subtypes as well as descriptive statements that indicate the severity and course of the illness.

CASE STUDY Mr. C.

Psychosocial history: Mr. C., a 60-year-old man, was brought to the hospital by ambulance immediately following a suicide attempt by hanging. This hospitalization marked his first contact with the mental healthcare system. Mr. C. arrived combative and in four-point restraints and presented with the chief complaint, "I just wanted to die. . . . I feel hopeless and lost." According to the client, he had been feeling depressed for 2 months preceding the attempt and had experienced diminished appetite, insomnia, anhedonia, hopelessness, helplessness, and worthlessness during the 2 weeks prior to his suicide attempt.

The client identified that his troubles began 1 year prior, when his cardiologist advised Mr. C. to leave a job that he had held for over 30 years because of his compromised physical condition following a coronary bypass operation. Although Mr. C. had not planned an early retirement, he heeded the physician's advice and applied for disability payments. He soon fell into debt, resulting from the lengthy waiting period for disability payments, family weekend gambling excursions to Atlantic City, and accumulating medical bills. Mr. C., who had always been the head of household in his traditional family, felt that he had no choice but to return to work. He also became noncompliant with his heart medications, began to withdraw from social events, had frequent arguments with his wife, and experienced a reemergence of chest pain.

Mr. C. finally terminated his employment a few months later, upon receipt of disability checks. A month prior to the suicide attempt, Mr. C. received notification from the disability office that he was ineligible for the entitlement because he had worked for those few months after having applied and that he owed $4,000 in back pay. It was also around this time that his teenaged grandson was incarcerated for armed robbery.

Mr. C. had no previous psychiatric history. He did not use drugs or alcohol, but has smoked one pack per day for 40 years. His medical history was significant for heart disease. Mr. C. had a family history of hypertension and heart disease. He reported that his mother suffered from postpartum depression after the birth of her third child, which resolved without treatment. Mr. C. was the oldest of three children in a middle class family. Mr. C. met normal developmental milestones. Mr. C.'s father died when he was 14 years of age, after which Mr. C. was forced to drop out of school in order to work to help support his family. Although Mr. C. was close with his siblings in his youth, he fell out of touch with them after their mother passed away. He and his wife had been married for nearly 40 years at the time of the hospitalization. Their two grown children were living out of state. Mr. C. was normally in close contact with his children by tele-

The **multiaxial DSM-IV-TR diagnosis** is divided into five categories, or axes.

Axis I

Axis I comprises mostly clinical disorders such as major depression, chronic schizophrenia, and attention deficit disorder. Specific diagnostic criteria, consisting of the signs and symptoms of the illnesses, are provided for each of these disorders. Some of these criteria must be present before a diagnosis is made, and other symptoms may accompany them. The information obtained through the interview and testing is compared with the signs and symptoms found in the descriptions of the *DSM-IV-TR* for specific disorders.

Axis II

Axis II includes personality disorders and mental retardation, along with the related diagnostic signs and symptoms. Axis II diagnoses are deemed secondary to Axis I diagnoses, unless it is clearly stated that the client's primary diagnosis is on Axis II. Axis I and Axis II together contain the entire classification of mental disorders, numbering over 300 illnesses. This list of disorders is large but incomplete because the classification system constantly evolves through research.

Axis III

Axis III denotes the client's physical disorders or medical conditions. A medical illness may be the cause of the mental disorder (e.g., human immunodeficiency virus [HIV] infection on Axis III with dementia secondary to HIV infection on Axis I), the result of the mental disorder (e.g., cirrhosis on Axis III with alcohol dependence on Axis I), or unrelated to the mental disorder.

Axis IV

Axis IV recognizes psychosocial and environmental factors that may precipitate, result from, or affect the treatment of mental illness. Axis IV lists

phone. He had several close friendships through his job and from his church, but lately had not been socially involved with anyone besides immediate family.

Although Mr. C. had never earned his high school diploma, he had a successful career with the local utilities company until his recent health problems. Mr. C. verbalized a strong belief that the male in the household should be the primary provider for his family and that the woman should tend to the home. Mr. C. considered himself religious, regularly attended services, and took comfort in his belief in God. When asked about coping skills, Mr. C. reported that in the past he talked about his problems with friends and his priest. He reported that smoking gives him some relief from anxiety.

On the mental status examination, Mr. C. was a well-groomed Caucasian man who appeared older than his years. His posture was poor, and he exhibited psychomotor retardation. He was cooperative with the interview for 20 minutes, after which point he stated that he was too tired to continue. The client's mood was depressed, with a depressed affect that was constricted in range. His speech was slow, soft, and nonspontaneous. Mr. C. evinced no formal thought disorder. Mr. C. denied experiencing hallucinations, and there was no evidence of delusional thought. He expressed ambivalence about having survived his suicide attempt but stated that he had no plan to try again while in the hospital, because he wanted to see if we could help him with his problems. Mr. C. stated that perhaps his surviving the attempt was God's way of telling him that other people needed him here on earth. His impulse control, judgment, and insight were poor to fair, as shown by his gambling, going back to work against his doctor's advice, noncompliance with cardiac medications, impulsive suicide attempt, and ambivalence about his survival. Mr. C. was alert and oriented to person, place, and time. His memory for recent history was intact, and his concentration seemed mildly impaired. His level of intellect was deemed average, and he seemed to be a reliable historian.

Mr. C. rated his depression by using the Beck Depression Inventory, scoring in the range indicative of severe depression. The review of Mr. C.'s activities of daily living was significant for diminished appetite with a 20-pound weight loss as well as initial insomnia over the past year. His laboratory tests were all within normal limits. Mr. C.'s physical examination was significant for hypertension.

See **Table 3-7** for the diagnostic formulation for Mr. C., and Nursing Care Plan: Mr. C.—Depression for the associated nursing care plan.

Table 3-7 Diagnostic Formulation of Mr. C.

DSM-IV-TR Diagnosis	NANDA-I Diagnosis
Axis I: 296.2 Major Depressive Disorder, Single Episode Axis II: 312.31 Provisional Diagnosis: Pathological Gambling 799.9 Diagnosis deferred on Axis II Axis III: Atherosclerotic Heart Disease, Hypertension Axis IV: Adjustment to forced early retirement, medical illness, financial difficulties, family discord Axis V: GAF = 20 (on admission to hospital)	Risk for suicide related to depression and stressful life events, manifested by serious suicide attempt Ineffective health maintenance related to financial difficulties and depression, manifested by noncompliance with cardiac medication Imbalanced nutrition: less than body requirements related to depression, manifested by decreased appetite and weight loss Sleep deprivation related to depression, manifested by insomnia Situational low self-esteem related to medical illness, forced early retirement, and depression; manifested by inability to maintain family finances and marital discord

Note: DSM-IV-TR = Diagnostic and Statistical Manual of Mental Disorders, 4th ed., Text Revision; NANDA-I*/Nursing Diagnoses: Definitions and Classifications, 2007–2008;* GAF = global assessment of functioning

NURSING CARE PLAN Mr. C.—Depression

Expected Outcomes	Interventions	Evaluations
• Will not make suicidal gestures	• Monitor client on a 1:1 observation	• Evaluating for suicidal thoughts, plan, intent, lethality, and access to means each shift • Assessing the client's reasons to continue living
• Will sleep 6–7 hours a night	• Teach relaxation techniques	• Evaluating the client's demonstration of relaxation techniques, evaluating number of hours slept nightly
• Will improve nutritional intake	• Assess for likes and dislikes, encouraging small, frequent meals, referring to a nutritionist	• Monitoring for weight gain on a weekly basis
• Will learn alternative coping mechanisms	• Assist the client in identifying coping mechanisms that have worked in the past in similar situations	• Observing for increased use of adaptive coping mechanisms
• Will be compliant with treatment	• Teach the client about heart disease and treatment	• Monitoring compliance with cardiac medication
• Will have improved sense of self-worth	• Identify and assist in correcting cognitive distortions	• Administering Beck Depression Inventory at regular intervals
• Will establish contact with community resources	• Discuss possible community resources and support systems	• Evaluating the client's participation in a heart disease support group

Visit http://nursing.jbpub.com/book/psychiatric for additional care plans and exercises.

psychosocial and environmental events that would have a strong impact on the average person and that were experienced by the client in the year preceding the evaluation. Events occurring prior to that time should not be included unless they are catastrophic, in which case they may be directly involved in the etiology of the mental disorder (e.g., childhood abuse leading to PTSD). Stressors may include negative events, such as job loss, as well as events ordinarily deemed positive, such

as the birth of a child. The *DSM-IV-TR* categorizes these stressors into clusters that the clinician should use as evaluation guidelines. The client's specific problems should be listed under Axis IV.

Axis V

Axis V indicates the client's overall ability to function. Using the **Global Assessment of Functioning (GAF) scale**, the interviewer rates the client's total psychological, social, and occupational or academic well-being on a scale of 1 to 100 (1 being virtually nonfunctional and 100 being asymptomatic with superior function in all realms). Both the severity of psychiatric symptoms and the degree of social, work, or school impairment are considered on the scale, which represents a continuum of mental health and mental illness. A person's GAF score changes over time, thus the clinician must rate the client for the most pertinent time period (e.g., upon admission, upon discharge, highest level in past year) and identify the time frame of the rating. The GAF score is useful when operationalizing a client's progress from admission to discharge. It is also helpful in formulating a prognosis; a high premorbid GAF score portends a good prognosis.

Outcome Identification and Planning of Nursing Care

The initial nursing care plan is based on the comprehensive assessment and attendant nursing diagnoses, with consideration of the medical diagnosis. Initial planning of care marks the final phase of the psychiatric client's evaluation. The care plan consists of the nursing diagnoses or problem list, outcome goals, interventions used to attain these outcomes, and evaluation of the interventions and their efficacy in achieving desired outcomes. Outcome identification is an important part of the nursing process; interventions cannot be delineated without first outlining the goals of the interventions (ANA, 2007).

The outcome measures should be client-centered, realistic, observable, measurable, specific, time-limited, and mutually agreed upon by client and nurse. Some diagnoses lend themselves to easily operationalized outcome measures, and others present some difficulty as a result of the subjective nature of the probe. For example, outcome measures for altered nutrition are more easily quantified than are measures for self-esteem disturbance.

In early care planning, the goal is to identify and explore urgent problems. Initial care planning should be done in collaboration with the client, family, and other members of the interdisciplinary treatment team. The **therapeutic contract** is the agreement between the nurse and client to work on these mutually identified problems. A contract may be in written form or may be a verbal agreement. Especially in the beginning of treatment, the amount and type of collaboration client and family offers may be limited; the nurse must then accept the balance of responsibility for treatment. Some clients actively resist collaboration. When this is the case, the nurse's first priority is to engage the client in treatment by setting firm limits, providing positive reinforcement for small steps, and persevering against resistance.

Interventions in the nursing care plan focus on improving the client's ability to function and quality of life. Some examples of interventions available to the psychiatric nurse include counseling, milieu therapy, self-care assistance, medication administration, education, case management, and health promotion. In addition, advanced practice nurses may implement psychotherapy, prescribe pharmacologic agents, and provide consultation.

In many settings, generic or standardized nursing care plans and contracts for specific nursing diagnoses, medical diagnostic groups, or client problems exist. These plans are good guidelines but should be tailored to the individual client's needs.

The comprehensive multiaxial *DSM-IV-TR* diagnosis is congruent with nursing's biopsychosocial paradigm.

The nurse-client relationship is collaborative; the nurse and client share responsibility for the client's care. The healthier the client is, the more responsibility he or she is given.

Summary

Holistic evaluation of the psychiatric client consists of assessing the client's biopsychosocial history and current mental status through the psychiatric nursing interview. The specific content and process of the interview depends upon the nurse, the client, and the context in which the interview takes place. In terms of content, the biopsychosocial history includes the client's chief complaint; HPI; psychiatric history; alcohol and substance use history; medical, family, developmental, social, occupational, or educational histories; culture; spirituality; and coping skills. The mental status examination comprises an evaluation of the client's current behavior and appearance; emotions: mood and affect; speech; thought content and process; perceptual disturbances; impulse control; cognition and sensorium; and knowledge, insight, and judgment. The nurse may remember these components with the acronym *BEST PICK*.

In terms of process, the psychiatric nursing interview consists of a beginning, middle, and termination phase. The primary task of the beginning phase is to develop a rapport with the client. The bulk of information sharing is done during the middle phase. The termination phase relaxes the client and summarizes the meeting. Interviewing techniques such as nodding one's head, reflecting feelings, and restating content facilitate the interaction; bombarding the client with questions and denying his or her feelings are detrimental to the interview. Transference and countertransference (the conscious or unconscious feelings, expectations, beliefs, and attitudes the client and clinician have for one another) may also influence the interview positively or negatively.

The *DSM-IV-TR* diagnosis is a multiaxial medical diagnosis that considers major mental illness as well as personality, intellectual functioning, medical illness, psychosocial stressors, and global functioning. The assessment data from the psychiatric nursing interview (with consideration of the *DSM-IV-TR* diagnosis, psychological testing results, and medical workup outcome) are used to formulate nursing diagnoses. These diagnoses are prioritized with input from the client, and safety is the primary concern. The nurse collaborates with the client in formulating the initial nursing care plan, which consists of the identified problems (nursing diagnoses), projected treatment outcomes and interventions, and evaluation of the process.

Annotated References

American Nurses Association. (2007). *Psychiatric-mental health nursing: Scope and standards of practice*. Washington, DC: American Nurses Publishing.

This text outlines the ANA's recommendations for psychiatric nursing practice. It guides the practice of all psychiatric nurses, especially those new to the field. Psychiatric nurses should keep up with current nursing trends by reading the latest version of the ANA's statement.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

This is the fourth edition of the American Psychiatric Association's official nomenclature of psychiatric conditions and disorders.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

This is the text revision of the fourth edition of the American Psychiatric Association's official nomenclature of psychiatric conditions and disorders. It provides a systematic listing of the official codes and categories, a description of the multiaxial system for diagnosis, and diagnostic criteria for each of the disorders. It is used by psychiatrists, physicians, psychologists, registered nurses, social workers, therapists, and other mental health workers in all clinical settings. The 2000 text revision includes new research information regarding associated features; culture, age, and gender features; prevalence; course; and familial pattern of many of the mental disorders listed.

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This psychiatric nursing text focuses on the often forgotten spiritual aspect of the nurse-client relationship.

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This article advocates for the use of scientific data collection tools by nurses as a way of enhancing professionalism and patient care.

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This pioneering work regarding the evolution of personality over one's lifetime is easy to understand and apply to practice. Development is put into historical and sociological perspective, and the role of the child in society is also explored.

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This article introduced the mini-mental status examination and scoring method.

Goldstein, E. G. (1995). *Ego psychology and social work practice* (2nd ed.). New York: Free Press.

Although aimed at a social work audience, this text applies to nursing practice; both professions are attracted to ego psychology's engagement of the health and strengths of the client. Assessment is viewed from an ego psychologic vantage point, stressing both defense mech-

anisms and the rational and problem-solving capacities of the ego. Problems in functioning are viewed in relation to possible coping deficits and the fit between inner capacities and environmental resources. The text's easy-to-understand chapter on the assessment of defense mechanisms is an excellent resource.

Govier, I. (2000). Spiritual care in nursing: A systematic approach. *Nursing Standard, 14*(17), 32–36.
This article advocates for taking a systemic approach to assessing clients' spiritual needs. The need for nurses to evaluate personal spirituality before effectively assessing clients' spiritual needs is also discussed.

Gresenz, C. R., Sturm, R., & Tang, L. (2001). Income and mental health: Unraveling community and individual level relationships. *Journal of Mental Health Policy and Economics, 4*(4), 197–203.
A study by the Rand Organization that examined the relationship between mental disorder and socioeconomic status. The findings confirmed earlier studies that showed individual income to be highly correlated with mental health status.

Guy, W. (1976). *ECDEU Assessment Manual for Psychopharmacology.* Washington, DC: U.S. Department of Health, Education and Welfare.
This is the original publication of the Abnormal Involuntary Movement Scale (AIMS).

Kadushin, A. (1997). *The social work interview: A guide for human services professionals* (4th ed.). New York: Columbia University Press.
This book applies to the work of all mental health professionals. It contains detailed discussion of the beginning, middle, and termination phases of the interview and of the clinician-client relationship. A thoughtful chapter is included regarding the use of humor and self-disclosure in the therapeutic relationship. This edition includes extended information on listening, nonverbal communication, use of interpreters, and interviewing involuntary adults and sexually abused children.

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The authors review the use of seven psychiatric self-rating scales and discuss their usefulness across cultures.

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This nursing research study, based on patient interviews conducted at Duke University, identified measures of religiosity and spirituality. Religiousness and spirituality predicted fewer depressive symptoms, and organized religious activities predicted better physical functioning and less severe illness.

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This study examined the relationship between religious characteristics of older medically ill patients with depression and those of medically ill nondepressed patients. Depression was less severe in patients who identified a religious affiliation and formal religious practices.

National Child Traumatic Stress Network (2004). *Childhood traumatic grief educational materials*. Los Angeles, CA: National Center for Child Traumatic Stress. www.NCTSNet.org
This is an in-depth general information guide to childhood traumatic grief with information specific to healthcare providers, parents, and school personnel. It includes a useful reference and resource list.

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This article analyzed data on 665 African Americans and white psychiatric patients and found that, even when a semi-structured diagnostic instrument and DSM criteria were used, whites were more likely than African Americans to receive a diagnosis of bipolar disorder and less likely to be diagnosed with schizophrenia.

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This overview of the effects of smoking and smoking cessation in psychiatric clients is essential to understanding the pros and cons of the recent antismoking movement in healthcare settings.

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This article stresses the importance of the nurse's use of his or her experience and judgment in the contemporary healthcare environment.

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This text targets psychiatrists in training; thus, the authors tend to stress the biologic aspect of assessment (i.e., genetics, brain anatomy and physiology, neurotransmitters). It is an excellent reference for psychiatric nurses.

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This article outlines an efficient psychiatric nursing assessment model based on King's nursing theory.

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This chapter provides a conceptual framework for viewing the family's experience of a relative's mental illness. The chapter discusses several factors associated with the family and the mentally ill relative that impact upon the meaning of the illness to the family.

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This article investigates those aspects of childhood trauma that follow the patient into adulthood. The author delineates the consequences of single versus multiple childhood traumas and provides helpful case examples.

Vannicelli, M. (1992). *Removing the roadblocks: Group psychotherapy with substance abusers and family members*. New York: Guilford Press.

Although this book's focus is the specialty area of group therapy for substance abusers, the excellent information concerning transference, countertransference, and resistance generalizes to group and individual treatment of all psychiatric clients.

Vedantam, S. (2005, June 26). Patients' diversity is often discounted. *The Washington Post,* pp. A01, A10.

This article contains a discussion of how the presentation of mental illness differs across cultures.

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Although this book is intended for caseworkers and not nurses, it contains useful information regarding the therapeutic relationship that applies to a wide range of mental health professionals.

Internet Resources

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Visit http://nursing.jbpub.com/book/psychiatric for interactive exercises, NCLEX review questions, WebLinks, and more.