5 Ethical and Legal Issues

CORE CONCEPTS

Bioethics

Ethics

Moral Behavior

Rights

Values

Values Clarification

CHAPTER OUTLINE

Objectives
Homework Assignment
Ethical Considerations
Legal Considerations
Summary and Key Points
Review Questions
Clinical Judgment Questions

KEY TERMS

advocacy
assault
autonomy
battery
beneficence
bioethics
Christian ethics
civil law
common law
criminal law
defamation of character
ethical dilemma
ethical egoism
ethics
false imprisonment
informed consent
justice
Kantianism
libel
malpractice
moral behavior
natural law theory
negligence
nonmaleficence
privileged communication
rights
slander
statutory law

tort
utilitarianism
values
values clarification
veracity

OBJECTIVES

After reading this chapter, the student will be able to:

1. Differentiate between *ethics, morals, values,* and *rights.*
2. Discuss ethical theories, including *utilitarianism, Kantianism, Christian ethics, natural law theories,* and *ethical egoism.*
3. Define *ethical dilemma.*
4. Discuss the ethical principles of *autonomy, beneficence, nonmaleficence, justice,* and *veracity.*
5. Use an ethical decision-making model to make an ethical decision.
6. Describe ethical issues relevant to psychiatric-mental health nursing.
7. Define *statutory law and common law.*
8. Differentiate between *civil law* and *criminal law.*
9. Discuss legal issues relevant to psychiatric-mental health nursing.
10. Differentiate between *malpractice* and *negligence.*
11. Identify behaviors relevant to the psychiatric-mental health setting for which specific malpractice action could be taken.

HOMEWORK ASSIGNMENT

Please read the chapter and answer the following questions:

1. Malpractice and negligence are examples of what kind of law?
2. What charges may be brought against a nurse for confining a patient against his or her wishes (outside of an emergency situation)?
3. Which ethical theory espouses that what is right and good is what is best for the individual making the decision?
4. Name the three major elements of informed consent.

Nurses are constantly faced with the challenge of making difficult decisions regarding good and evil or life and death. Complex situations frequently arise in caring for individuals with mental illness, and nurses are held to the highest level of legal and ethical accountability in their professional practice. This chapter presents basic ethical and legal concepts and their relationship to psychiatric-mental health nursing. A discussion of ethical theory is presented as a foundation on which ethical decisions may be made. The American Nurses Association (ANA) (2015) has established a code of ethics for nurses to use as a framework within which to make ethical choices and decisions. These revised provisions and interpretive guidelines have been expanded to address some of the complexities of the current health-care environment and include ethical principles regarding the nurse's duty not only to the patient but also to himself or herself and all people with whom he or she interacts. According to the code, the nurse's primary responsibility is to the patient (whether that is an individual, family, group, community, or population) and all relationships should be conducted within a culture of respect and civility.

The ANA Code of Ethics interpretive guidelines include a discussion of the importance of teamwork and collaboration, which is consistent with one of the recommendations of the Institute of Medicine (IOM) (2003) (now renamed the National Academy of Medicine) for improving the future of health care and has become one of the Quality and Safety Education for Nurses (QSEN) standards.

The ANA, in cooperation with the American Psychiatric Nurses Association and the International Society of Psychiatric-Mental Health Nurses (2014), has published a scope and standards of practice manual specifically for psychiatric-mental health nursing. It maintains consistency with the ANA code of ethics and applies those provisions to psychiatric-mental health nursing issues. Knowledge about the *Code of Ethics for Nurses* (ANA, 2015) and *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* (ANA et al., 2014) is essential for guiding practice because they clarify the accepted expectations of the nurse in this field.

Because legislation determines what is *right* or *good* within a society, legal issues pertaining to psychiatric-mental health nursing are also discussed in this chapter. Definitions are presented along with a description of the generally accepted and legal rights of psychiatric clients. Nursing competency and client care accountability are compromised when the nurse has inadequate knowledge about the laws that regulate the practice of nursing.

Application of the legal and ethical concepts presented in this chapter will enhance the quality of care the nurse provides in his or her psychiatric-mental health nursing practice and will also protect the nurse within the parameters of legal accountability. The right to practice nursing carries with it the responsibility to maintain a specific level of competency and to practice in accordance with certain ethical and legal standards of care.

CORE CONCEPTS

Ethics is a branch of philosophy that deals with systematic approaches to distinguishing right from wrong behavior (Butts & Rich, 2019). **Bioethics** is the term applied to these principles when they refer to concepts within the scope of medicine, nursing, and allied health.

Moral behavior is conduct that results from serious critical thinking about how individuals ought to treat others. Moral behavior reflects the way a person interprets basic respect for other persons, such as the respect for autonomy, freedom, justice, honesty, and confidentiality.

Values are personal beliefs about what is important and desirable (Butts & Rich, 2019). **Values clarification** is a process of self-exploration through which individuals identify and rank their personal values. This process increases awareness about why individuals behave in certain ways. Values clarification is important in nursing to increase understanding about why choices and decisions are made over others and how values affect nursing outcomes.

Rights are expectations to which an individual is entitled either by established laws, policies, or ethical principles. A right is *absolute* when there is no restriction whatsoever on the individual's entitlement. A *legal right* is one on which the society has agreed and formalized into law. Both the National League for Nursing (NLN) and the American Hospital Association (AHA) have established guidelines of patients' rights. Although these are not considered legal documents, nurses and hospitals are responsible for upholding these rights of patients.

Ethical Considerations

Theoretical Perspectives

An *ethical theory* is a set of philosophical principles that can be used to guide how an individual makes decisions on ethical questions and issues. Several ethical theories are described here.

Utilitarianism

The basis of **utilitarianism** is the “greatest-happiness principle.” This principle holds that actions are right to the degree that they tend to promote happiness and are wrong as they tend to produce the reverse of happiness. Thus, the good is happiness and the right is that which promotes the good. Conversely, the wrongness of an action is determined by its tendency to bring about unhappiness. An ethical decision based on the utilitarian view looks at the end results of the decision. Action is taken on the basis of the end results that will produce the most good (happiness) for the most people.

Kantianism

Named for philosopher Immanuel Kant, **Kantianism** is directly opposed to utilitarianism. Kant argued that it is not the consequences or end results that make an action right or wrong; rather, it is the principle or motivation on which the action is based that is the morally decisive factor. Kantianism suggests that our actions are bound by a sense of duty. This theory is often called *deontology* (from the Greek word *deon,* which means “that which is binding; duty”). Kantian-directed ethical decisions are made out of respect for moral law. For example, “I make this choice because it is morally right and my duty to do so” (not because of consideration for a possible outcome).

Christian Ethics

This approach to ethical decision making is focused on the way of life and teachings of Jesus Christ. It advances the importance of virtues such as love, forgiveness, and honesty. One basic principle often associated with Christian ethics is known as the golden rule: “Do unto others as you would have them do unto you.” The imperative demand of **Christian ethics** is that all decisions about right and wrong should be centered in love for God and in treating others with the same respect and dignity with which we would expect to be treated.

Natural Law Theory

Natural law theory is based on the writings of St. Thomas Aquinas. It advances the idea that decisions about right versus wrong are self-evident and determined by human nature. The theory espouses that, as rational human beings, we inherently know the difference between good and evil (believed to be the knowledge that is given to man from God), and this knowledge directs our decision making.

Ethical Egoism

Ethical egoism espouses that what is right and good is what is best for the individual making the decision. An individual's actions are determined by what is to his or her advantage. The action may not be best for anyone else involved, but consideration is only for the individual making the decision.

Ethical Dilemmas

An **ethical dilemma** in nursing is a situation that requires the nurse to make a choice between two equally unfavorable alternatives (Catalano, 2015). Evidence exists to support both moral "rightness" and moral "wrongness" related to a certain action. The individual who must make the choice experiences conscious conflict regarding the decision.

Not all ethical issues are dilemmas. An ethical dilemma arises when there is no clear reason to choose one action over another. Ethical dilemmas generally create a great deal of emotion. Often, the reasons supporting each side of the argument for action are logical and appropriate. The actions associated with both sides are desirable in some respects and undesirable in others. In most situations, taking no action is considered an action taken. For example, consider a patient who refuses to take a prescribed cardiac medication, claiming that he does not believe it is necessary. Although each patient has the right to refuse medication under ordinary circumstances, if the same patient is known to be depressed and suicidal, might he be intending self-harm by his refusal to take such a medication? And, if so, what is the best course of action? Many health-care settings have established guidelines for how to proceed should an ethical question or dilemma arise.

Hospitals typically have a formal committee to explore and analyze ethical issues from several vantage points. Nurses can improve their critical thinking and clinical judgment skills by identifying such issues and seeking clarification through collaborative exploration with others and through ethics committee involvement.

Ethical Principles

Ethical principles are fundamental guidelines that influence decision making. The ethical principles of autonomy, beneficence, nonmaleficence, veracity, and justice are examples that are used frequently by health-care workers to assist with ethical decision making.

Autonomy

The principle of **autonomy** arises from the Kantian view of persons as autonomous moral agents whose right to determine their destinies should always be respected. This view presumes that individuals are always capable of making independent choices. Health-care workers know this is not always the case. Children, comatose individuals, and some people with serious mental illness are incapable of making informed choices. In these instances, a representative of the individual is usually asked to intervene and give consent. However, health-care workers must ensure that respect for an individual's autonomy is not disregarded in favor of what another person may view as best for the client.

Beneficence

Beneficence refers to one's duty to benefit or promote the good of others. Health-care workers who act in their clients' interests are beneficent, provided their actions serve the client's best interest. In fact, some duties do take preference over other duties. For example, the duty to respect the autonomy of an individual may be overridden when that individual has been deemed harmful to self or others. "Doing good" for the patient should not be confused with "doing whatever the patient wants" (What do I do now? 2013). Good care must include a holistic focus that considers the patient's beliefs,

feelings, and wishes; the wishes of the family and significant others; and considerations about competent nursing care (Catalano, 2015). Despite these guidelines, it is not always clear which action *is* in the best interest of the client. When such dilemmas occur, nurses should reach out to available resources, such as an ethics committee or a supervisor, to build confidence that their decisions have explored various vantage points.

Peplau (1991) recognized client **advocacy** as an essential role for the psychiatric nurse. The term *advocacy* means acting in another's behalf as a supporter or defender. Being a patient advocate in psychiatric nursing means helping patients fulfill needs that, without assistance and because of their illness, may go unfulfilled. Individuals with mental illness are not always able to speak for themselves. Nurses serve in this manner to protect patients' rights and interests. Strategies include educating patients and their families about their legal rights, ensuring that patients have sufficient information to make informed decisions or to give informed consent, assisting patients to consider alternatives, and supporting them in the decisions they make. Additionally, nurses may act as advocates by speaking on behalf of individuals with mental illness to secure essential mental health services.

Nonmaleficence

Nonmaleficence is the requirement that health-care providers do no harm to their clients, either intentionally or unintentionally. Some philosophers suggest that this principle is more important than beneficence; that is, they support the notion that it is more important to avoid doing harm than it is to do good. In any event, ethical dilemmas arise when a conflict exists between an individual's rights and what is thought to best represent the welfare of the individual. An example of this conflict might occur when a psychiatric patient refuses antipsychotic medication (consistent with his or her rights), and the nurse must then decide how to maintain patient safety while psychotic symptoms continue.

Justice

The principle of **justice** has been referred to as the "justice as fairness" principle. It is sometimes called *distributive justice,* and its basic premise lies with the right of individuals to be treated equally and fairly regardless of race, gender, marital status, medical diagnosis, social standing, economic level, or religious belief (Catalano, 2015). When applied to health care, the principle of justice suggests that all resources (including health-care services) ought to be distributed equally to all people. Thus, according to this principle, the vast disparity in the quality of care dispensed to the various socioeconomic classes within our society would be considered unjust. *Retribution* or *restorative justice* refers to the rules for responding when expectations for fairness are violated. *Social justice* can be summarized as the principle that rules for both distribution and rules for retribution should be fair and people should play by the rules (Maiese, 2017). It is important for nurses to recognize that in the latest revision of the *Code of Ethics for Nurses* (ANA, 2015), a new focus in one of the provisions states that nursing should integrate principles of social justice both in practice and in developing health policy.

Veracity

The principle of **veracity** refers to one's duty to always be truthful. Catalano (2015) states that veracity "requires the health-care provider to tell the truth and not intentionally deceive or mislead clients" (p. 126). There are times when limitations must be placed on this principle, such as when the truth would knowingly produce harm or interfere with the recovery process. Being honest is not always easy, but rarely is lying justified. Clients have the right to know about their diagnosis, treatment, and prognosis.

A Model for Making Ethical Decisions

The following steps may be used in making an ethical decision. These steps closely resemble the steps of the nursing process.

1. **Assessment:** Gather the subjective and objective data about a situation. Consider personal values as well as values of others involved in the ethical dilemma.

2. **Problem identification:** Identify the conflict between two or more alternative actions.
3. **Planning:**
   a. Explore the benefits and consequences of each alternative.
   b. Consider principles of ethical theories.
   c. Select an alternative.
4. **Implementation:** Act on the decision made and communicate the decision to others.
5. **Evaluation:** Evaluate outcomes.

A schematic of this model is presented in Figure 5-1. A case study using this decision-making model is presented in Box 5-1. If the outcome is acceptable, action continues in the manner selected. If the outcome is unacceptable, benefits and consequences of the remaining alternatives are reexamined, and steps 3 through 7 in Box 5-1 are repeated.

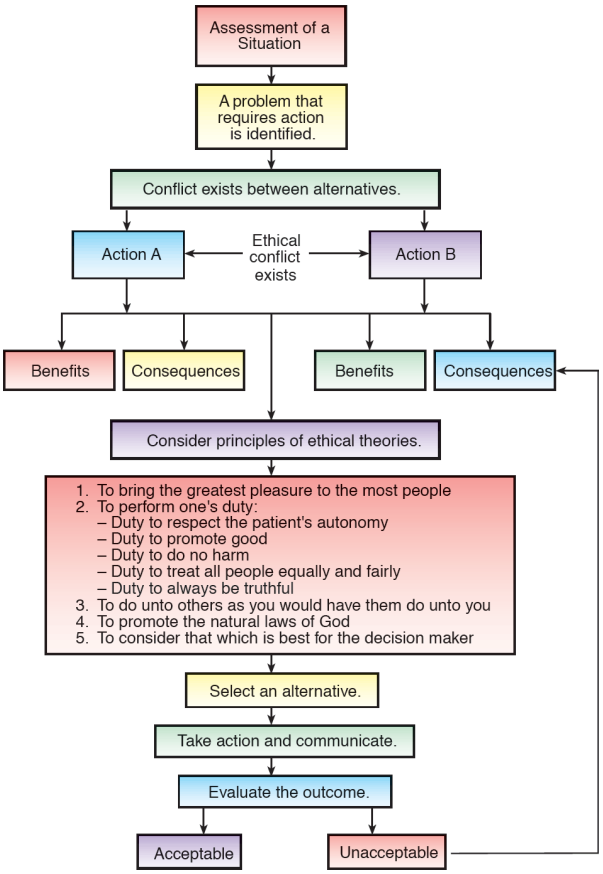

FIGURE 5-1 Ethical decision-making model.

Ethical and Legal Issues in Psychiatric-Mental Health Nursing

The Right to Treatment

Anyone who is admitted to the hospital has the right to treatment. For example, a psychiatric patient cannot legally be hospitalized and then denied appropriate treatment. The American Hospital Association (AHA) has also identified the rights of hospitalized patients. The AHA patient bill of rights was originally written with an emphasis on protecting the patient from a breach of reasonable standards while hospitalized. These guidelines were revised in 2003 to create an emphasis on the importance of the collaborative relationship between the patient and the hospital health-care team. Titled “The Patient Care Partnership,” this document informs patients of their rights to high-quality care while hospitalized, to a clean and safe environment, to be involved in their own care, to have their privacy protected, to get help when leaving the hospital, and to get help with their billing claims (AHA, 2003). In 2010 federal law expanded patient rights to include insurability despite preexisting conditions. However, federal health-care law continues to be a debated issue and will no doubt continue to change depending on the prevailing political climate. Nurses practicing in hospital settings need to be aware of and adhere to legal statutes, accepted standards of practice, and organizational policies with regard to a client’s rights during hospital treatment.

The Right to Refuse Treatment (Including Medication)

Legally, patients have the right to refuse treatment unless immediate intervention is required to prevent death or serious harm to the patient or another person (Sadock, Sadock, & Ruiz, 2015). The U.S. Constitution and several of its amendments affirm this right (e.g., the First Amendment, which addresses the rights of speech, thought, and expression; the Eighth Amendment, which grants the right to freedom from cruel and unusual punishment; and the Fifth and Fourteenth Amendments, which grant due process of law and equal protection for all). In psychiatry, however, both ethical and legal

issues must be considered. Sometimes patients are involuntarily hospitalized because they are at risk of harm to themselves or others and do not recognize the severity of their symptoms. In emergency cases, sedative medication may be administered without the patients' consent in order to protect them from harming themselves or others. Because laws vary from state to state, nurses must know the laws that pertain in their local jurisdictions. Organizational policies in the nurse's practice setting should also guide decision making.

Although many courts support a client's right to refuse medications in the psychiatric area, exceptions do exist. Regarding decision making about forced medication, Weiss-Kaffie and Purtell (2001) stated:

> The treatment team must determine that three criteria be met to force medication without client consent. The client must exhibit behavior that is dangerous to self or others; the medication ordered by the physician must have a reasonable chance of providing help to the client; and clients who refuse medication must be judged incompetent to evaluate the benefits of the treatment in question. (p. 361)

Evidence supports the long-term benefits of involuntary medication, particularly for patients with schizophrenia and bipolar disorders (Mental Illness Policy Org, 2017). Current research, demonstrating the particular benefits of treating a first episode of psychosis as important in decreasing long-term negative consequences, may increase acceptability of involuntary medication as an early intervention when needed.

More recently, some states have adopted laws that allow a court to mandate outpatient treatment for people with mental illness who have a history of violent behavior. In New York City, this law, known as *Kendra's law,* also includes a provision for ordering an individual to take medication as part of the treatment plan.

BOX 5–1 **Ethical Decision Making—A Case Study**

STEP 1. ASSESSMENT

Tonja is a 17-year-old girl who is currently on the psychiatric unit with a diagnosis of conduct disorder. Tonja reports that she has been sexually active since she was 14. She had an abortion when she was 15 and a second one 6 weeks ago. She states that her mother told her she has "had her last abortion" and that she has to start taking birth control pills. She asks her nurse, Kimberly, to give her some information about the pills and to tell her how to go about getting some. Kimberly believes Tonja desperately needs information about birth control pills and other types of contraceptives, but the psychiatric unit is part of a Catholic hospital, and hospital policy prohibits distributing this type of information.

STEP 2. PROBLEM IDENTIFICATION

A conflict exists between the patient's need for information, the nurse's desire to provide that information, and the institution's policy prohibiting the provision of that information.

STEP 3. ALTERNATIVES—BENEFITS AND CONSEQUENCES

Alternative 1: Give the patient information and risk losing job.

Alternative 2: Do not give client information and compromise own values of holistic nursing.

Alternative 3: Refer the patient to another source outside the hospital and risk reprimand from supervisor.

STEP 4. CONSIDER PRINCIPLES OF ETHICAL THEORIES

Alternative 1: Giving the patient information would certainly respect the patient's autonomy and would benefit her by decreasing her chances of becoming pregnant again. It would not be to the best advantage of Kimberly in that she would likely lose her job. According to the beliefs of the Catholic hospital, the natural laws of God would be violated.

Alternative 2: Withholding information restricts the patient's autonomy. It has the potential for doing harm in that without the use of contraceptives, the patient may become pregnant again (and she implies that this is not what she wants). Kimberly's

Christian ethic is violated in that this action is not what she would want "done unto her."

Alternative 3: A referral would respect the patient's autonomy, would promote good, would do no harm (except perhaps to Kimberly's ego from the possible reprimand), and would comply with Kimberly's Christian ethic.

STEP 5. SELECT AN ALTERNATIVE

Alternative 3 is selected on the basis of the ethical theories of utilitarianism (does the most good for the greatest number of people), Christian ethics (Kimberly's belief of "Do unto others as you would have others do unto you"), and Kantianism (to perform one's duty) and on the basis of the ethical principles of autonomy, beneficence, and nonmaleficence. The success of this decision depends on the patient's follow-through with the referral and compliance with use of the contraceptives.

STEP 6. TAKE ACTION AND COMMUNICATE

Taking action involves providing information in writing for Tonja or perhaps making a phone call to set up an appointment for her with a health clinic. Communicating involves sharing the information with Tonja's mother. The referral should be documented in the patient's chart.

STEP 7. EVALUATE THE OUTCOME

An acceptable outcome might indicate that Tonja kept her appointment at the health clinic and is complying with the prescribed contraceptive regimen. It might also include Kimberly's input into the change process in her institution to implement these types of referrals to other patients who request them.

An unacceptable outcome might be indicated by Tonja's lack of follow-through with the appointment at the health clinic or lack of compliance in using the contraceptives, resulting in another pregnancy. Kimberly may also view a reprimand from her supervisor as an unacceptable outcome, particularly if she is told that she must select other alternatives should this situation arise in the future. Kimberly's disagreement with the institution's policy may motivate

her to make another decision—that of seeking employment in an institution that supports a philosophy more consistent with her own.

The Right to the Least Restrictive Treatment Alternative

The right to the least restrictive treatment alternative means that clients who can be adequately treated in an outpatient setting should not be hospitalized, and if they are hospitalized, they should not be sedated, restrained, or secluded unless less restrictive measures were unsuccessful. In other words, the client has a right to whatever level of treatment is effective and least restricts his or her freedom. The restrictiveness of psychiatric therapy can be described in the context of a continuum based on severity of illness. Clients may be treated on an outpatient basis, in day hospitals, or through voluntary or involuntary hospitalization. Symptoms may be treated with verbal rehabilitative techniques and move successively to behavioral techniques, chemical interventions, mechanical restraints, or electroconvulsive therapy. However, ethical issues arise in selecting the least restrictive means among involuntary chemical intervention, seclusion, and mechanical restraints. Sadock and associates (2015) state:

> Distinguishing among these interventions on the basis of restrictiveness proves to be a purely subjective exercise fraught with personal bias. Moreover, each of these three interventions is both more and less restrictive than each of the other two. Nevertheless, the effort should be made to think in terms of restrictiveness when deciding how to treat patients. (p. 1,386)

While the right to the least restrictive treatment may seem reasonable and expected, it is important to recognize that clients with mental illness have historically been hospitalized against their will simply because they had a mental illness. In the case of *O'Connor v. Donaldson* (1976), the Supreme Court ruled that harmless mentally ill individuals cannot be confined against their will if they are able to remain safe outside of a hospital setting. They must be considered dangerous to themselves or others or be so unable to care for themselves that their safety and survival are at

risk. In 1981 the case of *Roger v. Oken* culminated in the ruling that all patients, even those involuntarily hospitalized, are competent to refuse treatment, but a legal guardian may authorize treatment (Sadock et al., 2015). These laws and policies have better attempted to protect the rights of clients with mental illness while still recognizing that, at times, an individual with acute mental illness may be unable to make decisions in the interest of his or her safety and survival.

Ideally, a person recognizes his or her need for treatment and agrees voluntarily to be hospitalized if this measure is recommended by the health-care provider. The client who is voluntarily hospitalized typically signs a consent to treatment upon admission, but the client maintains the right as a voluntary patient to revoke that consent and to be discharged from the hospital if he or she so chooses.

Legal Considerations

The Patient Self-Determination Act, as part of the Omnibus Budget Reconciliation Act of 1990, went into effect on December 1, 1991. Cady (2010) states:

> The Patient Self-determination Act requires healthcare facilities to provide clear written information for every patient concerning his/her legal rights to make healthcare decisions, including the right to accept or refuse treatment. (p. 118)

Box 5-2 lists the rights of patients affirmed by this law.

Nurse Practice Acts

The legal parameters of professional and practical nursing are defined within each state by the state's nurse practice act. These documents are passed by the state legislature and are generally concerned with provisions such as the following:

- The definition of important terms, including nursing itself and the various types of nurses.

- A statement of the education and other training or requirements for licensure and reciprocity.
- Broad statements that describe the scope of practice for various levels of nursing (APN, RN, LPN).
- Conditions under which a nurse's license may be suspended or revoked and instructions for appeal.
- The general authority and powers of the state board of nursing.

Most nurse practice acts are general in their terminology and do not provide specific guidelines for practice. Nurses must understand the scope of practice protected by their license and should seek assistance from legal counsel if they are unsure about the proper interpretation of a nurse practice act.

Types of Law

The two general categories of law that are of most concern to nurses are statutory law and common law. These laws are identified by their source or origin.

Statutory Law

A **statutory law** is a law that has been enacted by a legislative body, such as a county or city council, state legislature, or the U.S. Congress. Examples of statutory laws are nurse practice acts.

Common Law

Common laws are derived from decisions made in previous cases. These laws apply to a body of principles that evolve from court decisions resolving various controversies. Because common law in the United States has been developed by individual states, the law on specific subjects may differ from state to state. An example of a common law might be how different states deal with a nurse's refusal to provide care for a specific client.

Classifications Within Statutory and Common Law

Broadly speaking, there are two kinds of unlawful acts: civil and criminal. Both statutory law and common law have civil and criminal components.

Civil Law

Civil law protects the private and property rights of individuals and businesses. Private individuals or groups may bring a legal action to court for breach of civil law. These legal actions are of two basic types: torts and contracts.

BOX 5–2 **Patient Self-Determination Act—Patient Rights**

A person admitted to a program or facility for the purpose of receiving mental health services should be accorded the following:

1. The right to appropriate treatment and related services in a setting and under conditions that are the most supportive of such person's personal liability and that restrict such liberty only to the extent necessary consistent with such person's treatment needs, applicable requirements of law, and applicable judicial orders.
2. The right to an individualized, written treatment or service plan (such plan to be developed promptly after admission of such person), the right to treatment based on such plan, the right to periodic review and reassessment of treatment and related service needs, and the right to appropriate revision of such plan, including any revision necessary to provide a description of mental health services that may be needed after such person is discharged from such program or facility.
3. The right to ongoing participation, in a manner appropriate to a person's capabilities, in the planning of mental health services to be provided (including the right to participate in the development and periodic revision of the plan).
4. The right to be provided, in terms and language appropriate to a person's condition and ability to understand, a reasonable explanation of the person's general mental and physical (if appropriate) condition, the objectives of treatment, the nature and significant possible adverse effects of recommended treatment, the reasons a particular treatment is considered appropriate, the reasons access to certain visitors may not be appropriate, and any appropriate and available alternative treatments, services, and types of providers of mental health services.
5. The right not to receive a mode or course of treatment in the absence of informed, voluntary, written consent to treatment except during an emergency situation or as permitted by law when the person is being treated as a result of a court order.
6. The right not to participate in experimentation in the absence of informed, voluntary, written consent (includes human subject

protection).

7. The right to freedom from restraint or seclusion, other than as a mode or course of treatment or restraint or seclusion during an emergency situation with a written order by a responsible mental health professional.
8. The right to a humane treatment environment that affords reasonable protection from harm and appropriate privacy with regard to personal needs.
9. The right to access, on request, to such person's mental health-care records.
10. The right, in the case of a person admitted on a residential or inpatient care basis, to converse with others privately, to have convenient and reasonable access to the telephone and mail, and to see visitors during regularly scheduled hours. (For treatment purposes, specific individuals may be excluded.)
11. The right to be informed promptly and in writing at the time of admission of these rights.
12. The right to assert grievances with respect to infringement of these rights.
13. The right to exercise these rights without reprisal.
14. The right of referral to other providers upon discharge.

Adapted from the U.S. Code, Title 42, Section 10841, The Public Health and Welfare, 1991.

Torts

A **tort** is a violation of a civil law in which an individual has been wronged. In a tort action, one party asserts that wrongful conduct on the part of the other has caused harm and seeks compensation. A tort may be *intentional* or *unintentional.* Examples of unintentional torts are malpractice and negligence actions. An example of an intentional tort is the touching of another person without that person's consent. Intentional touching (e.g., a medical treatment) without the client's consent can result in a charge of battery, an intentional tort.

Contracts

In a contract action, one party asserts that the other party, in failing to fulfill an obligation, has breached the contract, and either compensation or performance of the obligation is sought as remedy. An example is an action by a mental health professional whose clinical privileges have been reduced or terminated in violation of an implied contract between the professional and a hospital.

Criminal Law

Criminal law provides protection from conduct deemed injurious to the public welfare. It provides for punishment of those found to have engaged in such conduct, which commonly includes imprisonment, parole conditions, a loss of privilege (such as a license), a fine, or any combination of these (Ellis & Hartley, 2012). An example of a violation of criminal law is the theft by a hospital employee of supplies or drugs.

Legal Issues in Psychiatric-Mental Health Nursing

Confidentiality and Right to Privacy

The Fourth, Fifth, and Fourteenth Amendments to the U.S. Constitution protect an individual's right to privacy. Most states have statutes protecting the confidentiality of client records and communications. Nurses must recognize that the only individuals who have a right to observe a client or have access to medical information are those involved in the client's medical care. The client must provide written consent for health-care information to be shared with anyone outside the current treatment team.

Health Insurance Portability and Accountability Act (HIPAA)

Until 1996 client confidentiality in medical records was not protected by federal law. In August 1996 President Clinton signed the Health Insurance Portability and Accountability Act (HIPAA) into law. This federal privacy rule pertains to data that is called *protected health information* (PHI) and applies to most individuals and institutions involved in health care. PHI is defined as individually identifiable

health information indicators that “relate to past, present, or future physical or mental health or condition of the individual, or the past, present, or future payment for the provision of health care to an individual and (1) that identifies the individual; or (2) with respect to which there is a reasonable basis to believe the information can be used to identify the individual” (U.S. Department of Health and Human Services, 2003). These specific identifiers are listed in Box 5-3.

Under HIPAA, individuals have the rights to access their medical records, have corrections made to their medical records, and decide with whom their medical information may be shared. The actual document belongs to the facility or the therapist, but the information contained therein belongs to the client. The passage of HIPAA increased the level of control clients have over the information maintained in their medical records. Notice of privacy policies must be provided to clients upon entry into the health-care system.

In 2013 HIPAA privacy and security rules were again expanded to afford more rights to patients concerning their medical information and to ensure greater security of a person’s health information. In some cases, such as when paying out of pocket for care, patients can tell a provider that they do not want treatment information shared with their health insurance plan (U.S. Department of Health & Human Services, 2013). Nurses in any practice setting need to be aware of these HIPAA laws and any new legal provisions that will affect the conduct of their practice.

Pertinent medical information may be released without consent in a life-threatening situation. If information is released in an emergency, the following information must be recorded in the client’s record: date of disclosure, person to whom information was disclosed, reason for disclosure, reason written consent could not be obtained, and the specific information disclosed.

Most states have statutes that pertain to the doctrine of **privileged communication.** Although the codes differ markedly from state to state, most grant certain professionals privileges under which they may refuse to reveal information about and communications with clients. In most states, the doctrine of privileged communication

applies to psychiatrists and attorneys; in some instances, psychologists, clergy, and nurses are also included.

BOX 5–3 **Protected Health Information (PHI): Individually Identifiable Indicators**

1. Names
2. Postal address information (except state), including street address, city, county, precinct, and zip code
3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older
4. Telephone numbers
5. Fax numbers
6. Electronic mail addresses
7. Social Security numbers
8. Medical record numbers
9. Health plan beneficiary numbers
10. Account numbers
11. Certificate/license numbers
12. Vehicle identifiers and serial numbers, including license plate numbers
13. Device identifiers and serial numbers
14. Web Universal Resource Locators (URLs)
15. Internet protocol (IP) address numbers
16. Biometric identifiers, including finger and voice prints
17. Full face photographic images and any comparable images
18. Any other unique identifying number, characteristic, or code

From U.S. Department of Health and Human Services (HHS). (2003). Standards for privacy of individually identifiable health information. *Washington, DC: HHS.*

In certain instances, nurses may be called on to testify in cases in which the medical record is used as evidence. In most states, the

right to privacy of these records is exempted in civil or criminal proceedings. Therefore it is important that nurses document with these possibilities in mind. Strict record-keeping using objective and nonjudgmental statements, care plans that are specific in their prescriptive interventions, and documentation that describes those interventions and their subsequent evaluation, all serve the best interests of the client, the nurse, and the institution should questions regarding care arise. Documentation often weighs heavily in malpractice case decisions.

The right to confidentiality is a basic one, especially in psychiatry. Although societal attitudes are improving, individuals have experienced discrimination in the past for no other reason than having a history of mental illness. Nurses working in psychiatric-mental health nursing must guard the privacy of their patients with great diligence.

Exception: A Duty to Warn (Protection of a Third Party)

There are exceptions to the laws of privacy and confidentiality. One of these exceptions stems from the 1974 case of *Tarasoff v. Regents of the University of California.* The incident from which this case evolved occurred in the late 1960s. A young man from Bengal, India (Mr. P.), who was a graduate student at the University of California (UC), Berkeley, fell in love with another university student (Ms. Tarasoff). Because she was not interested in an exclusive relationship with Mr. P., he became resentful and angry. He began to stalk her and record some of their conversations in an effort to determine why she did not love him. He soon became very depressed and neglected his health, appearance, and studies.

Ms. Tarasoff spent the summer of 1969 in South America. During this time, Mr. P. entered therapy with a psychologist at UC. He confided in the psychologist that he intended to kill his former girlfriend (identifying Ms. Tarasoff by name) when she returned from vacation. The psychologist recommended civil commitment for Mr. P. and claimed that he had a diagnosis of acute and severe paranoid schizophrenia. Mr. P. was picked up by the campus police but released a short time later because he appeared rational and

promised to stay away from Ms. Tarasoff. Neither Ms. Tarasoff nor her parents received any warning of Mr. P.'s stated intention to kill her.

When Ms. Tarasoff returned to campus in October 1969, Mr. P. resumed his stalking behavior and eventually stabbed her to death. Ms. Tarasoff's parents sued the psychologist, several psychiatrists, and the university for failure to warn the family of the danger. The case was referred to the California Supreme Court, which ruled that a mental health professional has a duty not only to a client but also to individuals who are being threatened by that client. The Court stated:

> Once a therapist does in fact determine, or under applicable professional standards should have determined, that a patient poses a serious danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger. While the discharge of this duty of due care will necessarily vary with the facts of each case, in each instance the adequacy of the therapist's conduct must be measured against the traditional negligence standard of reasonable care under the circumstances. (*Tarasoff v. Regents of University of California,* 1974a)

The defendants argued that warning the woman or her family would have breached professional ethics and violated the client's right to privacy. But the court ruled that "the confidential character of patient-psychotherapist communications must yield to the extent that disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins" (*Tarasoff v. Regents of University of California,* 1974b).

In 1976 the California Supreme Court expanded the original case ruling (now referred to as *Tarasoff I*). The second ruling (known as *Tarasoff II*) broadened the ruling of "duty to warn" to include "duty to protect." It stated that under certain circumstances, a therapist might be required to warn an individual, notify police, or take whatever steps are necessary to protect the intended victim from harm. This duty to protect can also apply to health-care providers who are required to protect patients who are vulnerable due to their inability to identify harmful situations (Guido, 2014).

The *Tarasoff* rulings created a great deal of controversy in the psychiatric community regarding breach of confidentiality and the subsequent negative impact on the client-therapist relationship. However, most states now recognize that therapists have ethical and legal obligations to prevent their clients from harming themselves or others. Many states have passed their own variations on the original "protect and warn" legislation, but in most cases, courts have outlined the following guidelines for therapists to follow in determining their obligation to take protective measures:

1. Assessment of a threat of violence by a client toward another individual
2. Identification of the intended victim
3. Ability to intervene in a feasible, meaningful way to protect the intended victim

When these guidelines apply to a specific situation, it is reasonable for the therapist to notify the victim, law enforcement authorities, or relatives of the intended victim. They may also consider initiating voluntary or involuntary commitment of the client to prevent potential violence.

Implications for Nursing While the original decision in the Tarasoff ruling was directed toward psychotherapists, it has since been more broadly applied. Not all states identify registered nurses as having a duty to warn, but other statutes include a duty to warn for nurses at all levels, from licensed practical nurses to advanced practice nurses. As of 2018 three states (Maine, Nevada, and North Dakota) had not yet addressed the issue of duty to warn. One state (North Carolina) does not recognize the duty to warn (National Conference of State Legislatures, 2018). In 2018 New Jersey expanded its "duty to warn" law to require mental health professionals to notify local authorities whenever patients threaten harm to *themselves* or others (Sitrin, 2018). Although intended to promote greater gun safety by removing guns from people who are at risk of harming themselves or others with firearms, the law has far broader implications both professionally and politically.

Even in states that do not recognize a duty to warn, practitioners still must decide about warning a potential victim and others. Every nurse, not just those practicing in psychiatric nursing, should be informed about the laws in his or her state regarding duty to warn. As Henderson (2015) notes, emergency nurses are often the front-line health-care workers and thus are in a position to identify persons at risk for violence and to protect the safety of the patient and others. In psychiatric-mental health nursing practice, if a client confides in the nurse about the potential for harm to an intended victim, it is the nurse's duty to report this information to the psychiatrist and to other team members. Reporting this information is not a breach of confidentiality. In such situations, the nurse may be considered negligent for failure to report. All members of the treatment team must be made aware of the potential danger that the client poses to self or others. Detailed written documentation of the situation is also required.

Exception: Suspected Child or Elder Abuse

Every state requires that health-care professionals—and in many jurisdictions, every citizen—report suspicion of child abuse to legal authorities (Hartsell & Bernstein, 2013). Many jurisdictions also have statutes requiring that suspected elder abuse or neglect be reported. At times, health-care professionals may be reluctant to report, fearing that they may be liable for false allegations, but reporting statutes generally grant immunity to anyone making a good faith report about a reasonable suspicion. In addition, in some jurisdictions, it is a criminal act *not* to report; therefore "declining to report should not be considered an option" (Hartsell & Bernstein, 2013, p. 170).

Implications for Nursing There is often an element of clinical judgment about whether a patient's communication raises a reasonable suspicion of abuse. For example, when a person is experiencing hallucinations or delusions, his or her perception about events may be distorted. The nurse has a responsibility to explore all patient perceptions of abuse or mistreatment and discuss these with

other health-care team members to identify the most appropriate decision with consideration of all legal, ethical, and clinical factors.

Informed Consent

According to law, all individuals have the right to decide whether to accept or reject medical treatment. A health-care provider can be charged with assault and battery for providing life-sustaining treatment to a client when the client has not agreed to the treatment. The rationale for the doctrine of **informed consent** is the preservation and protection of individual autonomy in determining what will and will not happen to a person's body (Guido, 2014).

Informed consent is permission granted by a client to a physician to perform a therapeutic procedure. Before the procedure, the client is presented with written information about the treatment and given adequate time to consider the benefits and risks of the procedure. Information should include treatment alternatives; why the physician believes this treatment is most appropriate; the possible outcomes, risks, and adverse effects; the possible outcome should the client select another treatment alternative; and the possible outcome should the client choose to decline all treatment. An example of a psychiatric treatment that requires informed consent is electroconvulsive therapy.

Under some conditions, treatment may be performed without obtaining informed consent from the client. A client's refusal to accept treatment may be challenged under the following circumstances (Guido, 2014; Levy & Rubenstein, 1996):

1. When a client is mentally incompetent to make a decision and treatment is necessary to preserve life or avoid serious harm
2. When refusing treatment endangers the life or health of another
3. During an emergency in which a client is in no condition to exercise judgment
4. When the client is a child (consent is obtained from parent or surrogate)
5. In the case of therapeutic privilege, information about a treatment may be withheld if the physician can show that full disclosure

would

a. hinder or complicate necessary treatment,
b. cause severe psychological harm, or
c. be so upsetting as to render a rational decision by the client impossible

Although most clients in psychiatric-mental health facilities are competent and capable of giving informed consent, those with severe psychiatric illness may not possess the cognitive ability to do so. If an individual has been legally determined to be mentally incompetent, consent is obtained from the legal guardian. Difficulty arises when no legal determination has been made, but the individual's current mental state prohibits informed decision making (e.g., a person who is psychotic, unconscious, or inebriated). In these instances, informed consent is usually obtained from the individual's nearest relative, or if none exist and time permits, the physician may ask the court to appoint a conservator or guardian. When time does not permit court intervention, permission may be sought from the hospital administrator.

A client or guardian always has the right to withdraw consent after it has been given. When this occurs, the physician should inform (or reinform) the client about the consequences of refusing treatment. If treatment has already been initiated, the physician should terminate treatment in a way least likely to cause injury to the client and inform the client or guardian of the risks associated with interrupted treatment (Guido, 2014).

The nurse's role in obtaining informed consent is usually defined by agency policy. A nurse may sign the consent form as a witness for the client's signature. However, legal liability for informed consent lies with the physician. The nurse acts as a client advocate, ensuring that the following three major elements of informed consent have been addressed:

1. **Knowledge:** The client has received adequate information on which to base his or her decision.
2. **Competency:** The individual's cognition is not impaired to an extent that would interfere with decision making, or he or she has

a legal representative.

3. **Free will:** The individual has given consent voluntarily without pressure or coercion from others.

Restraints and Seclusion

An individual's privacy and personal security are protected by the Patient Self-Determination Act of 1991. This legislation includes a set of patient rights, including an individual's right to freedom from restraint or seclusion except in an emergency. The use of seclusion and restraint as a therapeutic intervention for psychiatric patients has long been controversial. Many efforts have been made through federal and state regulations and through standards set forth by accrediting bodies to minimize or eliminate the use of this type of intervention.

In addition, there is an element of moral decision making when any kind of treatment is coerced, as is often the case with seclusion and restraint. Landeweer, Abma, and Widdershoven (2011) point out that although coercion may sometimes be necessary, it can be detrimental to the patient, as it may produce trauma and mistrust. One advantage of using a forum such as a hospital-based ethics committee to guide moral decision making is that by exploring issues such as the use of seclusion and restraint with a diverse group of people who have different vantage points, alternative treatments can be identified and explored.

Because injuries and deaths have been associated with restraint and seclusion, this treatment requires careful attention whenever it is deemed necessary. Further, because laws, regulations, accreditation standards, and hospital policies are frequently revised, anyone practicing in inpatient psychiatric settings must remain well-informed in each of these areas.

In psychiatry, the term *restraints* generally refers to a set of leather straps used to restrain the extremities of an individual whose behavior poses an immediate risk to the physical safety and psychological well-being of himself or herself and others. It is important to note that the currently accepted definition of restraint refers not only to leather restraints but also to any manual method or

medication used to restrict a person's freedom of movement. Restraints are never to be used as punishment or for the convenience of staff. Other measures to decrease agitation, such as "talking down" (verbal intervention) and chemical restraints (tranquilizing medication), are usually tried first. If these interventions are ineffective, mechanical restraints may be instituted (although some controversy exists as to whether chemical restraints are indeed less restrictive than mechanical restraints). *Seclusion* is another type of physical restraint in which the client is confined alone in a room from which he or she is unable to leave. The room is usually minimally furnished with items to promote the client's comfort and safety.

The Joint Commission, an association that accredits health-care organizations, has established standards regarding the use of seclusion and restraint. Some examples of current standards include the following (The Joint Commission, 2017):

1. Staff are trained and competent to minimize the use of restraint and seclusion and, when use is indicated, to use restraint and seclusion safely.
2. Seclusion or restraint is discontinued as soon as possible regardless of when the order is scheduled to expire.
3. Unless state law is more restrictive, orders for restraint or seclusion must be renewed every 4 hours for adults ages 18 and older, every 2 hours for children and adolescents ages 9 to 17, and every hour for children younger than 9 years.
4. The initial assessment of an individual who is at risk for harming himself or herself, staff, or others includes identifying techniques to help the individual control his or her behavior; any preexisting medical conditions, physical disabilities, or other limitations that might place the individual at greater risk during restraint or seclusion; history of physical or sexual abuse or other trauma; and their preferences about whether they would like family notified in the event of an episode of seclusion or restraint.
5. Patients who are simultaneously restrained and secluded must be continuously monitored in person by trained staff. After the first

hour, a person in seclusion without restraints may be continuously monitored through simultaneous audio and video equipment if consistent with the individual's condition and wishes.

6. Staff who are involved in restraint and seclusion are trained and competent to assess the patient at the initiation of restraint or seclusion and every 15 minutes thereafter, including assessment for any signs of injury, proper application of restraints, nutrition and hydration, circulation and range of motion, vital signs, hygiene and elimination, physical and psychological status and comfort, and readiness for discontinuation of restraint or seclusion.

The laws, regulations, accreditation standards, and hospital policies related to restraint and seclusion share a common priority of maintaining patient safety for a procedure that has the potential to incur injury or death. The importance of close and careful monitoring cannot be overstated.

False imprisonment is the deliberate and unauthorized confinement of a person within fixed limits by the use of verbal or physical means (Ellis & Hartley, 2012). Health-care workers may be charged with false imprisonment for restraining or secluding—against the wishes of the client—anyone admitted to the hospital voluntarily. Should a voluntarily admitted client decompensate to a level that restraint or seclusion for protection of self or others is necessary, court intervention to determine competency and involuntary commitment is required to preserve the client's rights to privacy and freedom.

Hospitalization

Voluntary Admissions

Each year, more than 1 million people are admitted to health-care facilities for psychiatric treatment; of these admissions, approximately two-thirds are considered voluntary. To be admitted voluntarily, an individual makes direct application to the institution for services and may stay as long as treatment is deemed necessary. He or she may sign out of the hospital at any time unless the health-care professional determines that the client may be harmful to self or

others following a mental status examination and recommends that admission status be changed from voluntary to involuntary. Even when admission is considered voluntary, it is important to ensure that the individual comprehends the meaning of his or her actions, has not been coerced in any manner, and is willing to proceed with admission.

Involuntary Commitment

Although the term *involuntary hospitalization* is preferred by some over the term *involuntary commitment,* this process needs to be conducted with respect to state and federal law. Because involuntary hospitalization results in substantial restrictions of the rights of an individual, the admission process is subject to the guarantee of the Fourteenth Amendment to the U.S. Constitution that provides citizens protection against loss of liberty and ensures due process rights (Weiss-Kaffie & Purtell, 2001). Involuntary hospitalizations may be made for various reasons. Most states commonly cite the following criteria:

- The person is imminently dangerous to himself or herself (i.e., suicidal intent).
- The person is a danger to others (i.e., physically aggressive, violent, or homicidal).
- The person is unable to take care of basic personal needs (the "gravely disabled").

Under the Fourth Amendment, individuals are protected from unlawful searches and seizures without probable cause. Therefore the individual recommending involuntary hospitalization must show probable cause why the client should be hospitalized against his or her wishes; that is, the person must show that there is cause to believe that the client would be dangerous to self or others, is mentally ill and in need of treatment, or is gravely disabled.

Emergency Commitments

Emergency commitments are sought when an individual manifests behavior that is clearly and imminently dangerous to self or others.

These admissions are usually instigated by relatives or friends of the individual or by police officers, the court, or health-care professionals. Emergency commitments are time-limited, and a court hearing for the individual is scheduled, usually within 72 hours. At that time, the court may decide that the client may be discharged or, if deemed necessary and voluntary admission is refused by the client, an additional period of involuntary hospitalization may be ordered. In most instances, another hearing is scheduled for a specified time (usually in 7 to 21 days).

The Mentally Ill Person in Need of Treatment

A second type of involuntary commitment is for the observation and treatment of mentally ill persons in need of treatment. These commitments typically last longer than emergency commitments. Most states have established definitions of what constitutes "mentally ill" for purposes of state involuntary admission statutes. Some examples include individuals who, because of severe mental illness, are

- Unable to make informed decisions concerning treatment.
- Likely to cause harm to self or others.
- Unable to fulfill basic personal needs necessary for health and safety.

In determining whether commitment is required, the court looks for substantial evidence of abnormal conduct—evidence that cannot be explained by a physical cause. There must be "clear and convincing evidence" as well as probable cause to substantiate the need for involuntary hospitalization to ensure that an individual's constitutional rights are protected. As mentioned earlier, the U.S. Supreme Court, in *O'Connor v. Donaldson,* held that the existence of mental illness alone does not justify involuntary hospitalization. State standards require a specific effect or consequence caused by mental illness that involves danger or an inability to care for one's own needs. These clients are entitled to court hearings with representation, at which time determination of commitment and length of stay are

considered. Legislative statutes governing involuntary commitments vary among states.

Involuntary Outpatient Commitment

Involuntary outpatient commitment (IOC) is a court-ordered mechanism used to compel a person with mental illness to submit to treatment on an outpatient basis. A number of eligibility criteria for commitment to outpatient treatment have been cited (Appelbaum, 2001; Csere, 2013; Maloy, 1996; Torrey & Zdanowicz, 2001). Some of these criteria are as follows:

- A history of repeated decompensation requiring involuntary hospitalization.
- Likelihood that without treatment the individual will deteriorate to the point of requiring inpatient commitment.
- Presence of severe and persistent mental illness (e.g., schizophrenia or bipolar disorder) and limited awareness of the illness or need for treatment.
- The presence of severe and persistent mental illness contributing to a risk for homelessness, incarceration, violence, or suicide.
- The existence of an individualized treatment plan likely to be effective and a service provider who has agreed to provide the treatment.
- The risk for relapse and hospitalization related to noncompliance with treatment.

Most states have already enacted IOC legislation or currently have agenda resolutions that pertain to this topic. Most commonly, clients who are committed into the IOC programs are those with severe and persistent mental illness such as schizophrenia. The rationale behind the legislation is to improve preventive care and reduce the number of readmissions and lengths of hospital stays for these clients. The need for this type of legislation arose after it was recognized that patients with schizophrenia who did not meet criteria for involuntary hospital treatment were in some cases ultimately dangerous to themselves or others. In New York, public attention to this need arose after a man with schizophrenia who had stopped taking his

medication pushed a young woman into the path of a subway train. He would not have met criteria for involuntary hospitalization until he was deemed dangerous to others, but advocates for this legislation argued that there should be provisions to prevent violence rather than waiting until it happens. The subsequent law governing IOC in New York became known as Kendra's law for the woman who was pushed to her death. Opponents of this legislation fear that it may violate the individual rights of psychiatric clients without significant improvement in outcomes.

Research has attempted to evaluate whether IOC improves care, reduces lengths of stay in the hospital, and reduces episodes of violence. Some studies have shown positive outcomes with IOC, including a decrease in hospital readmissions (Ridgely, Borum, & Petrila, 2001; Swartz et al., 2001; Swartz & Swanson, 2008). However, a Cochrane literature review (Kisely, Campbell, & O'Reilly, 2017) concluded that compulsory community treatment resulted in no significant differences in service use, social functioning, mental state, or quality of life, although those in mandated outpatient treatment were less likely to be victims of crimes. The issues around whether IOC will improve treatment compliance and enhance quality of life in the community for individuals with severe and persistent mental illness will continue to be a focus of study and debate.

The Gravely Disabled Client

Many states have statutes that specifically define the "gravely disabled" client. For those that do not use this label, the description of the individual who is unable to take care of basic personal needs because of mental illness is very similar.

Gravely disabled is generally defined as a condition in which an individual, as a result of mental illness, is in danger of serious physical harm resulting from an inability to provide for basic needs such as food, clothing, shelter, medical care, and personal safety. Inability to care for oneself cannot be established by showing that an individual lacks the resources to provide the necessities of life. Rather, it is the inability to make use of available resources.

Should it be determined that an individual is gravely disabled, a guardian, conservator, or committee will be appointed by the court to ensure the management of the person and his or her estate. Legal restoration of competency requires another court hearing to reverse the previous ruling. The individual whose competency is being determined has the right to be represented by an attorney.

It is an ethical and legal duty to ensure that whenever coercive treatments are used, including involuntary hospitalizations, seclusion and restraint, involuntary outpatient commitments, mandated medication, and even prison commitments, the least restrictive intervention must first be considered. Sashadahran and Saraceno (2017) identify a current global shift toward more coercive care similar to that which existed before the community mental health movement. Citing increasing numbers of involuntary hospitalizations, they also note that in the United States there are currently three times as many individuals with mental illness in prisons as there are in hospitals, and that sexual predator laws in the United States allow indefinite hospital stays for serious sex offenders beyond their prison sentence completion. The authors posit that when risk management supersedes the most appropriate level of care for treatment, stigmatization of this population may increase (Sashadahran & Saraceno, 2017).

Nursing Liability

Mental health practitioners—psychiatrists, psychologists, psychiatric nurses, and social workers—have a duty to provide appropriate care based on the standards of their professions and the standards set by law. The standards of care for psychiatric-mental health nursing are presented in Chapter 8, “The Nursing Process in Psychiatric-Mental Health Nursing.”

Malpractice and Negligence

The terms **malpractice** and **negligence** are often used interchangeably. Negligence has been defined as failure to exercise the care toward others that a reasonable or prudent person would do in the circumstances or taking action that a reasonable person would

not. Negligence is accidental as distinguished from “intentional torts” (assault or trespass, for example) or from crimes, but a crime can also constitute negligence, such as reckless driving (Hill & Hill, 2018).

Any person may be negligent. In contrast, malpractice is a specialized form of negligence caused only by professionals. Malpractice may be defined as an act or continuing conduct of a professional that does not meet the standard of professional competence and results in provable damages to his or her client or patient. Such an error or omission may be through negligence, ignorance (when the professional should have known), or intentional wrongdoing (Hill & Hill, 2018).

In the absence of state statutes, common law is the basis of liability for injuries to clients caused by acts of malpractice and negligence by individual practitioners. In other words, most decisions of negligence in the professional setting are based on legal precedent (decisions that have been made previously about similar cases) rather than on any specific action taken by the legislature.

To summarize, when a breach of duty is characterized as malpractice, the action is weighed against the professional standard. When it is brought forth as negligence, the action is contrasted with what a reasonably prudent professional would have done in the same or similar circumstances.

Austin (2011) cites the following basic elements of a nursing malpractice lawsuit:

1. A duty to the patient existed, based on the recognized standard of care.
2. A breach of duty occurred, meaning that the care rendered was not consistent with the recognized standard of care.
3. The client was injured.
4. The injury was directly caused by the breach of a standard of care.

For the client to prevail in a malpractice claim, each of these elements must be proven. Jury decisions are generally based on the testimony of expert witnesses because members of the jury are

laypeople who cannot be expected to know what nursing interventions should have taken place. Without the testimony of expert witnesses, a favorable verdict usually goes to the defendant nurse.

Types of Lawsuits That Occur in Psychiatric Nursing

Most malpractice suits against nurses are civil actions, which means they are considered breach of conduct actions on the part of the professional from whom compensation is sought. The nurse in a psychiatric setting should be aware of the types of behavior that may result in malpractice charges.

The hospitalized psychiatric client has a basic right to confidentiality and privacy. A nurse may be charged with *breach of confidentiality* for revealing aspects about a client's case or even for revealing that an individual has been hospitalized if the client can show that making this information known resulted in harm.

When shared information is detrimental to the client's reputation, the person sharing the information may be liable for **defamation of character.** When the information is in writing, the action is called **libel.** Oral defamation is called **slander.** Defamation of character involves communication that is malicious and false (Ellis & Hartley, 2012). Occasionally, libel arises out of critical, judgmental statements written in the client's medical record. Nurses need to be very objective in their charting, backing up all statements with factual evidence.

Invasion of privacy is a charge that may result when a client is searched without probable cause. Many institutions conduct body searches on clients with mental illness as a routine intervention. In these cases, there should be a physician's order and written rationale showing probable cause for the intervention. Many institutions are reexamining their policies regarding this procedure.

Assault is an act that results in a person's genuine fear and apprehension that he or she will be touched without consent. **Battery** is the nonconsensual touching of another person. These charges can result when a treatment is administered to a client against his or her wishes and outside of an emergency situation.

Harm or injury need not have occurred for these charges to be legitimate.

For confining a client against his or her wishes outside of an emergency situation, the nurse may be charged with false imprisonment. Examples of actions that may invoke these charges include locking an individual in a room, taking a client's clothes for purposes of detainment against his or her will, and restraining a competent voluntary client who demands to be released.

Avoiding Liability

Catalano (2015) suggests the following proactive nursing actions to avoid nursing malpractice and the risk of lawsuits:

1. *Effective communication* with patients and other caregivers. The SBAR model of reporting information, which stands for situation, background, assessment, and recommendations, has been identified as a useful tool for effective communication with caregivers. Establishing rapport with clients encourages open and honest communication.
2. *Accurate and complete documentation in the medical record.*

 The electronic health record (EHR) has been identified as the best way to document and share this information. The use of best informatics sources is identified as an essential nursing competency (Institute of Medicine, 2003) and an important standard for quality and safety education in nursing (QSEN Institute, 2013).

3. *Complying with standards of care,* including those established within the profession (such as ANA standards) and those identified by specific hospital policies.
4. *Knowing the client,* which includes helping the client become involved in his or her care as well as understanding and responding to aspects of care in which the client is dissatisfied.
5. *Practicing within the nurse's level of competence and scope of practice,* which includes not only adhering to professional standards (those of the ANA and state boards of nursing) but also

keeping knowledge and nursing skills current through evidence-based literature, in-services, and continuing education.

Some clients appear to be more “suit prone” than others. Suit-prone clients are often very critical, complaining, uncooperative, and even hostile. A natural staff response to these clients is to become defensive or withdrawn. Either of these behaviors increases the likelihood of a lawsuit should an unfavorable event occur (Ellis & Hartley, 2012). No matter how high the nurse’s technical competence and skill, his or her insensitivity to a client’s complaints and failure to meet the client’s emotional needs often influence whether or not a lawsuit is generated. A great deal depends on the psychosocial skills of the health-care professional.

CLINICAL PEARLS

- **Always put the client’s rights and welfare first.**
- **Develop and maintain a good interpersonal relationship with each client and his or her family.**

Summary and Key Points

- *Ethics* is a branch of philosophy that addresses methods for determining the rightness or wrongness of one’s actions.
- *Bioethics* is the term applied to these principles when they refer to concepts within the scopes of medicine, nursing, and allied health.
- *Moral behavior* is conduct that results from serious critical thinking about how individuals ought to treat others.
- *Values* are personal beliefs about what is important or desirable.
- Rights are expectations to which an individual is entitled either by established laws, policies, or ethical principles.
- The ethical theory of utilitarianism is based on the premise that what is right and good is that which produces the most happiness for the most people.
- The ethical theory of Kantianism suggests that actions are bound by a sense of duty and that ethical decisions are made out of respect for moral law.

- The code of Christian ethics is that all decisions about right and wrong should be centered in love for God and in treating others with the same respect and dignity with which we would expect to be treated.
- The moral precept of the natural law theory is “do good and avoid evil.” Good is viewed as that which is inscribed by God into the nature of things. Evil acts are never condoned, even if they are intended to advance the noblest of ends.
- Ethical egoism espouses that what is right and good is what is best for the individual making the decision.
- Ethical principles include autonomy, beneficence, nonmaleficence, veracity, and justice.
- An ethical dilemma is a situation that requires an individual to decide between two equally unfavorable alternatives.
- Ethical issues may arise in psychiatric-mental health nursing around the client’s right to refuse medication and right to the least restrictive treatment alternative.
- Statutory laws are those that have been enacted by legislative bodies, and common laws are derived from decisions made in previous cases. Both types of laws have civil and criminal components.
- Civil law protects the privacy and property rights of individuals and businesses, and criminal law provides protection from conduct deemed injurious to the public welfare.
- Legal issues in psychiatric-mental health nursing center around confidentiality and the right to privacy, informed consent, restraints and seclusion, and commitment issues.
- Nurses are accountable for their own actions in relation to legal issues, and violation can result in malpractice lawsuits against the physician, the hospital, and the nurse.
- Developing and maintaining a good interpersonal relationship with the client and his or her family appears to be a positive factor when the question of malpractice is being considered.

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www.fadavis.com

Review Questions

1. The nurse decides to go against family wishes and tell the client of his terminal status because that is what she would want if she were the client. Which of the following ethical theories is considered in this decision?
   a. Kantianism
   b. Christian ethics
   c. Natural law theories
   d. Ethical egoism

2. The nurse decides to respect family wishes and not tell the client of his terminal status because that would bring the most happiness to the most people. Which of the following ethical theories is considered in this decision?
   a. Utilitarianism
   b. Kantianism
   c. Christian ethics
   d. Ethical egoism

3. The nurse decides to tell the client of his terminal status because she believes it is her duty to do so. Which of the following ethical theories is considered in this decision?
   a. Natural law theories
   b. Ethical egoism
   c. Kantianism
   d. Utilitarianism

4. The nurse assists the physician with electroconvulsive therapy on a client who has refused to give consent. With which of the following legal actions might the nurse be charged because of this nursing action?
   a. Assault
   b. Battery

c. False imprisonment
d. Breach of confidentiality

5. A competent, voluntary client has stated he wants to leave the hospital. The nurse hides his clothes to keep him from leaving. With which of the following legal actions might the nurse be charged because of this nursing action?
a. Assault
b. Battery
c. False imprisonment
d. Breach of confidentiality

6. Joe is very restless and is pacing the room. The nurse says to Joe, “If you don’t sit down in the chair and be still, I’m going to put you in restraints!” With which of the following legal actions might the nurse be charged because of this nursing action?
a. Defamation of character
b. Battery
c. Breach of confidentiality
d. Assault

Clinical Judgment Questions

7. A nurse reports to the supervisor that a depressed client is refusing medication to treat his heart condition and states he “would rather just die.” The nurse is not sure how to intervene because, although clients have a right to refuse medication, this client may be so depressed that his behavior represents risk for suicide. Which of these actions by the supervisor is a priority?
a. Tell the nurse that medication will have to be given forcibly if the client continues to refuse medication.
b. Instruct the nurse that, because the client is elderly, he is unable to make this decision and medication will need to be secretly mixed in his food.
c. Educate the nurse that the physician has the final say so the nurse should ask the physician what to do.

d. Activate appropriate hospital resources, such as an ethics committee, so this issue can be explored further.

8. A client on the psychiatric unit begins yelling out loud that no one is listening to him and that he is going to “blow up” soon. The orderly asks the nurse if he should go ahead and put the client in restraints for the safety of others. Which of these responses by the nurse is most appropriate?

a. Educate the orderly that restraints may never be initiated without a physician’s order.
b. Instruct the orderly that it would be best to see if the client can be assisted to calm down by listening to his concerns.
c. Instruct the orderly to put the client in restraints but make sure to assess the client every 15 minutes for issues regarding circulation, nutrition, respiration, hydration, and elimination.
d. Instruct the orderly to get others to assist him in restraining the client but be aware restraints should be discontinued at the earliest possible time regardless of when a physician’s order is scheduled to expire.

9. The nurse collects the following information during the admission assessment. For which of these pieces of data should the nurse take additional action to ensure that “duty to warn” laws are followed?

a. The client threatens violence toward another individual.
b. The client states he wants to kill everyone that has demons.
c. The client is having command hallucinations.
d. The client reveals paranoid delusions about another individual.

10. Which of these actions by the nurse demonstrates an application of the QSEN competency related to informatics?

a. Learns how to effectively communicate information using electronic health records
b. Provides a verbal report of client behavioral issues at shift change
c. Asks the supervisor for guidelines on how to prevent lawsuits

d. Reads journals to learn information about new treatments and approaches to nursing care

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UNIT **3**

Therapeutic Approaches in Psychiatric Nursing Care

6 Relationship Development

CORE CONCEPTS

Therapeutic

Relationship

CHAPTER OUTLINE

KEY TERMS

attitude
belief
concrete thinking
confidentiality
countertransference
empathy
genuineness
rapport
sympathy
transference
unconditional positive regard
values

OBJECTIVES

After reading this chapter, the student will be able to:

1. Describe the relevance of a therapeutic nurse-patient relationship.
2. Discuss the dynamics of a therapeutic nurse-patient relationship.
3. Discuss the importance of self-awareness in the nurse-patient relationship.
4. Identify goals of the nurse-patient relationship.
5. Identify and discuss essential conditions for a therapeutic relationship to occur.
6. Describe the phases of relationship development and the tasks associated with each phase.

HOMEWORK ASSIGNMENT

Please read the chapter and answer the following questions:

1. When the nurse's verbal and nonverbal interactions are congruent, he or she is thought to be expressing which characteristic of a therapeutic relationship?
2. Identify the phase of the nurse-patient relationship in which each of the following occurs:
   a. The nurse may become angry and anxious in the presence of the patient.
   b. A plan of action for dealing with stress is established.
   c. The nurse examines personal feelings about working with the patient.
   d. Nurse and patient establish goals of care.
3. What is the goal of using the Johari Window?
4. How do sympathy and empathy differ?
5. Write a one-page journal entry reflecting on patterns you notice in your relationships with others. How might you use this awareness in developing therapeutic relationship skills?

The nurse-patient relationship is the foundation on which psychiatric nursing is established. It is a relationship in which both participants must recognize each other as unique and important human beings. It is also a relationship in which mutual learning occurs. In today's health-care environment, patient-centered care is promoted as central to quality and safety, and the therapeutic relationship remains at the foundation of this tenet. Concepts that were advanced over 60 years ago (by Hildegard Peplau in 1952) and have been the core of nursing practice to the present day are now recognized by the larger medical community as not only still relevant but critical to improving quality and safety in health care. Peplau (1991) stated:

> Shall a nurse do things *for* a patient or can participant relationships be emphasized so that a nurse comes to do things *with* a patient as her share of an agenda of work to be accomplished in reaching a goal—health. *It is likely that the nursing process is educative and therapeutic when nurse and patient can come to know and to respect each other, as persons who are alike, and yet, different, as persons who share in the solution of problems.* (p. 9, emphasis in original)

This chapter examines the role of the psychiatric nurse and the use of self as a therapeutic tool in the nursing care of patients with mental illness. Phases of the therapeutic relationship are explored, and conditions essential to the development of a therapeutic relationship are discussed. The importance of values clarification in the development of self-awareness is emphasized.

CORE CONCEPT

Therapeutic Relationship
An interaction between two people (usually a caregiver and a care receiver) in which input from both participants contributes to a climate of healing, growth promotion, and/or illness prevention.

Role of the Psychiatric Nurse

What is a nurse? Undoubtedly, this question would elicit as many different answers as the number of people to whom it was presented. Nursing as a *concept* has probably existed since the beginning of the civilized world, with the provision of "care" for the ill or infirm by anyone in the environment who took the time to administer to those in need. However, the emergence of nursing as a *profession* only began in the late 1800s with the graduation of Linda Richards from the New England Hospital for Women and Children in Boston upon achievement of the diploma in nursing. Since that time, the nurse's role has evolved from that of custodial caregiver and physician's handmaiden to recognition as a unique, independent member of the professional health-care team.

Peplau (1991) identified the following nursing roles:

1. **The stranger:** A nurse is at first a stranger to the patient. The patient is also a stranger to the nurse. Peplau (1991) stated:

   > Respect and positive interest accorded a stranger is at first nonpersonal and includes the same ordinary courtesies that are accorded to a new guest who has been brought into any situation. This principle implies: (1) accepting the patient as he is; (2) treating the patient as an emotionally able stranger and relating to him on this basis until evidence shows him to be otherwise. (p. 44)

2. **The resource person:** According to Peplau, "A resource person provides specific answers to questions usually formulated with relation to a larger problem" (p. 47). In the role of resource person, the nurse explains, in language that the patient can understand, information related to the patient's health care.
3. **The teacher:** In this role, the nurse identifies learning needs and provides information required by the patient or family to improve the health situation.
4. **The leader:** According to Peplau, "Democratic leadership in nursing situations implies that the patient will be permitted to be an active participant in designing nursing plans for him" (p. 49). Autocratic leadership promotes overvaluation of the nurse and patients' substitution of the nurse's goals for their own. Laissez-faire leaders convey a lack of personal interest in the patient.
5. **The surrogate:** Outside of their awareness, patients often perceive nurses as symbols of other individuals. They may view the nurse as a mother figure, a sibling, a former teacher, or another nurse who has provided care in the past. This perception occurs when a patient is placed in a situation that generates feelings similar to ones he or she has experienced previously. Peplau (1991) explained that the nurse-patient relationship progresses along a continuum. When a patient is acutely ill, he or she may incur the role of infant or child, while the nurse is perceived as the mother surrogate. Peplau (1991) stated, "Each nurse has the responsibility for exercising her professional skill in aiding the relationship to move forward on the continuum, so that

person to person relations compatible with chronological age levels can develop" (p. 55).

6. **The technical expert:** The nurse understands various professional devices and possesses the clinical skills necessary to perform interventions that are in the best interest of the patient.
7. **The counselor:** The nurse uses "interpersonal techniques" to assist patients in adapting to difficulties or changes in life experiences. Peplau (1991) stated, "Counseling in nursing has to do with helping the patient to remember and to understand fully what is happening to him in the present situation, so that the experience can be integrated with, rather than dissociated from, other experiences in life" (p. 64).

Peplau (1962) believed that the counselor role is emphasized in psychiatric nursing. Many sources define the *nurse therapist* as a person with graduate preparation in psychiatric-mental health nursing. He or she has developed skills through intensive, supervised educational experiences to provide helpful individual, group, or family therapy. Peplau suggested that it is essential for the *staff nurse working in psychiatry* to have a general knowledge of basic counseling techniques. A therapeutic or "helping" relationship is established through use of these interpersonal techniques and is based on a sound knowledge of theories of personality development and human behavior.

Sullivan (1953) believed that emotional problems stem from difficulties with interpersonal relationships. Interpersonal theorists, such as Peplau and Sullivan, emphasize the importance of relationship development in the provision of emotional care. Through the establishment of a satisfactory nurse-patient relationship, individuals learn to generalize the ability to achieve satisfactory interpersonal relationships to other aspects of their lives.

Dynamics of a Therapeutic Nurse-Patient Relationship

Travelbee (1971), who expanded on Peplau's theory of interpersonal relations in nursing, stated that only when each individual in the interaction perceives the other as a unique human being is a relationship possible. She refers not to a nurse-patient relationship but rather to a human-to-human relationship, which she describes as a "mutually significant experience." That is, both the nurse and the recipient of care have needs met when each views the other as a unique human being, not as "an illness," as "a room number," or as "all nurses" in general.

Therapeutic relationships are goal oriented. Ideally, the nurse and patient decide together what the goal of the relationship will be. Most often, the goal is promotion of learning and growth to bring about change in the patient's life. In general, the goal of a therapeutic relationship may be based on a problem-solving model.

Example

Goal: The patient will demonstrate more adaptive coping strategies for dealing with (specific life situation).

Interventions:

- Identify what is troubling the patient at the present time.
- Encourage the patient to discuss changes he or she would like to make.
- Discuss which changes are possible and which are not possible.
- Explore feelings about aspects of his or her life that cannot be changed and alternative ways of coping more adaptively.
- Discuss alternative strategies for creating changes the patient desires to make.
- Weigh the benefits and consequences of each alternative.
- Assist the patient to select an alternative.
- Encourage the patient to implement the change.
- Provide positive feedback for the patient's attempts to create change.
- Assist the patient to evaluate outcomes of the change and make modifications as required.

Therapeutic Use of Self

Travelbee (1971) described the instrument for delivery of interpersonal nursing as the *therapeutic use of self,* which she defined as "the ability to use one's personality consciously and in full

awareness in an attempt to establish relatedness and to structure nursing intervention" (p. 19). Use of the self in a therapeutic manner requires that the nurse possess self-awareness and self-understanding, which are achieved by developing a philosophical belief about life, death, and the overall human condition. The nurse must understand that the ability to and the extent to which one can effectively help others in time of need is strongly influenced by this internal value system—a combination of intellect and emotions.

Gaining Self-Awareness

Values Clarification

Knowing and understanding oneself enhances the ability to form satisfactory interpersonal relationships. Self-awareness requires that an individual recognize and accept what he or she values and learn to accept the uniqueness of and differences in others. This concept is important in everyday life and in the nursing profession in general, but it is *essential* in psychiatric nursing.

An individual's value system is established very early in life and has its foundations in the value system held by one's primary caregivers. It is culturally oriented; consists of beliefs, attitudes, and values; and may change many times throughout one's lifetime. Values clarification is one process by which an individual may gain self-awareness.

Beliefs

A **belief** is an idea that one holds true, and it can take any of several forms:

- *Rational beliefs* are ideas for which objective evidence exists to substantiate their truth.
  - Example: Alcoholism is a disease.
- *Irrational beliefs* are ideas that an individual holds as true despite the existence of objective contradictory evidence. Delusions can be a form of irrational beliefs.
  - Example: Once an alcoholic has been through detoxification and rehabilitation, he or she can drink socially if desired.

- *Faith* (sometimes called *blind beliefs*) is a belief in something or someone that does not require proof.
  - Example: Belief in a higher power can help an alcoholic stop drinking.
- A *stereotype* is a socially shared belief that describes a concept in an oversimplified or undifferentiated matter.
  - Example: All alcoholics are skid-row bums.

Attitudes

An **attitude** is a frame of reference around which an individual organizes knowledge about his or her world. An attitude also has an emotional component. It can be a prejudgment and may be selective and biased. Attitudes fulfill the need to find meaning in life and to provide clarity and consistency for the individual. The prevailing stigma attached to mental illness is an example of a negative attitude. An associated stereotype might be that "all people with mental illness are dangerous."

Values

Values are abstract standards, positive or negative, that represent an individual's ideal mode of conduct and ideal goals. Examples of ideal modes of conduct include seeking truth and beauty; being clean and orderly; and behaving with sincerity, justice, reason, compassion, humility, respect, honor, and loyalty. Examples of ideal goals are security, happiness, freedom, equality, ecstasy, fame, and power.

Values differ from attitudes and beliefs in that they are action oriented or action producing. One may hold many attitudes and beliefs without behaving in a way that shows they hold those attitudes and beliefs. For example, a nurse may believe that all patients have the right to be told the truth about their diagnosis; however, he or she may not always act on the belief by telling all patients the complete truth about their conditions. Only when the belief is acted on does it become a value.

Attitudes and beliefs flow from one's set of values. An individual may have thousands of beliefs and hundreds of attitudes, but his or

her values probably number only in the dozens. Values may be viewed as a kind of core concept or basic standard that determines one's attitudes, beliefs, and ultimately, behavior. Raths, Harmin, and Simon (1978) identified a seven-step assessment process that can be used to help clarify personal values. This process is presented in Table 6–1. The process can be used by applying these seven steps to an attitude or belief that one holds. When an attitude or belief has met each of the seven criteria, it can be considered a personal value.

TABLE 6–1 The Process of Values Clarification

LEVEL OF OPERATIONS	CATEGORY	CRITERIA	EXPLANATION
Cognitive	Choosing	1. Freely 2. From alternatives 3. After careful consideration of the consequences	"This value is mine. No one forced me to choose it. I understand and accept the consequences of holding this value."
Emotional	Prizing	4. Satisfied; pleased with the choice 5. Making public affirmation of the choice, if necessary	"I am proud that I hold this value, and I am willing to tell others about it."
Behavioral	Acting	6. Taking action to demonstrate the value behaviorally 7. Demonstrating this pattern of behavior consistently and repeatedly	The value is reflected in the individual's behavior for as long as he or she holds it.

The Johari Window

The self arises out of self-appraisal and the appraisal of others. It represents each individual's unique pattern of values, attitudes, beliefs, behaviors, emotions, and needs. Self-awareness is the

recognition of these aspects and understanding about their impact on the self and others. The Johari Window, presented in Figure 6-1, is a representation of the self and a tool that can be used to increase self-awareness (Luft, 1970). The Johari Window is divided into four quadrants (four aspects of the self): the open self, the unknowing self, the private self, and the unknown self.

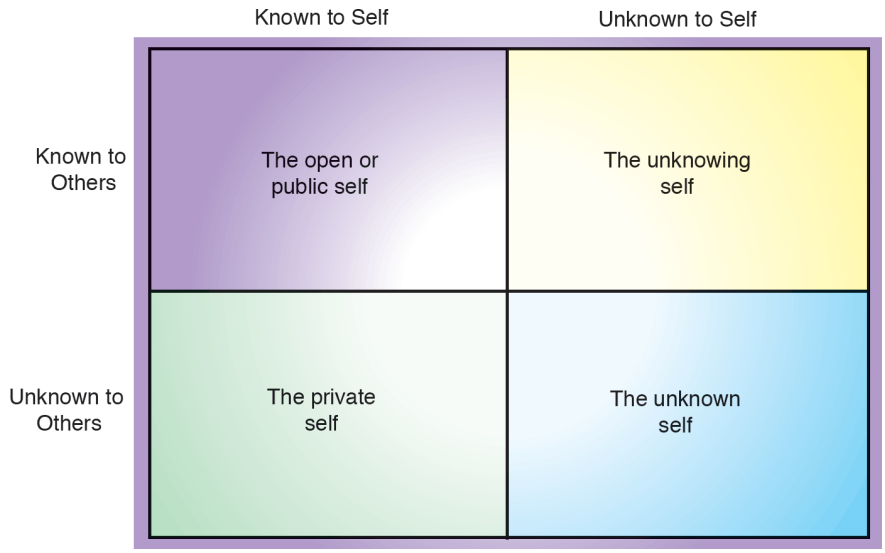

FIGURE 6-1 The Johari Window. (From Luft, J. [1970]. *Group processes: An introduction to group dynamics* [3rd ed.]. Palo Alto, CA: Mayfield Publishing, 1984, with permission.)

The Open or Public Self

The upper-left quadrant of the window represents the part of the self that is public; that is, aspects of the self about which both the individual and others are aware.

Example

Susan, a nurse who is the adult child of an alcoholic, has strong feelings about helping alcoholics to achieve sobriety. She volunteers her time as a support person on call to help recovering alcoholics. She is aware of her feelings and her desire to help others. Members of the Alcoholics Anonymous group in which she volunteers her time are also aware of Susan's feelings, and they feel comfortable calling her when they need help with refraining from drinking.

The Unknowing Self

The upper-right quadrant of the window represents the part of the self that is known to others but remains hidden from the awareness of the individual.

> **Example**
>
> When Susan takes care of patients in detoxification, she does so without emotion, tending to the technical aspects of the task in a way that the patients perceive as cold and judgmental. She is unaware that she comes across to patients in this way.

The Private Self

The lower-left quadrant of the window represents the part of the self that is known to the individual but which the individual deliberately and consciously conceals from others.

> **Example**
>
> Susan would prefer not to take care of the patients in detoxification because doing so provokes painful memories from her childhood. However, because she does not want the other staff members to know about these feelings, she volunteers to take care of the detoxification patients whenever they are assigned to her unit.

The Unknown Self

The lower-right quadrant of the window represents the part of the self that is unknown to both the individual and to others.

> **Example**
>
> Susan felt very powerless as a child growing up with an alcoholic father. She seldom knew in what condition she would find her father or what his behavior would be. She learned over the years to find small ways to maintain control over her life situation, and she left home as soon as she graduated from high school. The need to stay in control has always been very important to Susan, and she is unaware that working with recovering alcoholics helps to fulfill this need. The people she is helping are also unaware that Susan is satisfying an unfulfilled personal need as she provides them with assistance.

The goal of increasing self-awareness by using the Johari Window is to increase the size of the quadrant that represents the open or public self. The individual who is open to self and others is able to be

spontaneous and to share emotions and experiences with others. This individual also has a greater understanding of personal behavior and of others' responses to him or her. Increased self-awareness allows an individual to interact comfortably with others, to accept the differences in others, and to observe each person's right to respect and dignity.

Conditions Essential to Development of a Therapeutic Relationship

Several characteristics that enhance the achievement of a therapeutic relationship have been identified. These concepts are highly significant to the use of self as the therapeutic tool in interpersonal relationship development.

Rapport

Getting acquainted and establishing **rapport** is the primary task in relationship development. Rapport implies special feelings on the part of both the patient and the nurse based on acceptance, warmth, friendliness, common interest, a sense of trust, and a nonjudgmental attitude. Establishing rapport may be accomplished by discussing non–health-related topics. Travelbee (1971) states:

> [To establish rapport] is to create a sense of harmony based on knowledge and appreciation of each individual's uniqueness. It is the ability to be still and experience the other as a human being—to appreciate the unfolding of each personality one to the other. The ability to truly care for and about others is the core of rapport. (pp. 152, 155)

Trust

To trust another, one must feel confident in that person's presence, reliability, integrity, veracity, and sincere desire to provide assistance when requested. As summarized in Chapter 31, "Personality Disorders," and discussed in online Chapter 38, "Theoretical Models of Personality Development," trust is the initial developmental task described by Erikson. If the task has not been achieved, this

component of relationship development becomes more difficult. That is not to say that trust cannot be established, but only that additional time and patience may be required on the part of the nurse.

CLINICAL PEARL The nurse must convey trustworthiness, which requires that he or she possess a sense of self-confidence. Confidence in the self is derived from achievement of personal and professional goals and the ability to integrate the individual's various roles into functioning as a unified whole.

Trust cannot be presumed; it must be earned. Trustworthiness is demonstrated through nursing interventions that convey a sense of warmth and caring to the patient. These interventions are initiated simply and concretely and directed toward activities that address the patient's basic needs for physiological and psychological safety and security. Many psychiatric patients experience **concrete thinking,** which focuses their thought processes on specifics rather than generalities and on immediate issues rather than eventual outcomes. Examples of nursing interventions that promote trust in an individual who is thinking concretely include the following:

- Providing a blanket when the patient is cold
- Providing food when the patient is hungry
- Keeping promises
- Being honest (e.g., saying "I don't know the answer to your question, but I'll try to find out") and then following through
- Simply and clearly providing reasons for certain policies, procedures, and rules
- Providing a written, structured schedule of activities
- Attending activities with the patient if he or she is reluctant to go alone
- Being consistent in adhering to unit guidelines
- Listening to the patient's preferences, requests, and opinions and making collaborative decisions concerning his or her care whenever possible

- Ensuring **confidentiality**; providing reassurance that what is discussed will not be repeated outside the boundaries of the health-care team

Trust is the basis of a therapeutic relationship. The nurse working in psychiatry must perfect the skills that foster the development of trust. Trust must be established in order for the nurse-patient relationship to progress beyond the superficial level of tending to the patient's immediate needs.

Respect

To show respect is to believe in the dignity and worth of an individual regardless of his or her unacceptable behavior. The psychologist Carl Rogers called this **unconditional positive regard** (Raskin, Rogers, & Witty, 2014). The attitude is nonjudgmental, and the respect is unconditional in that it does not depend on the behavior of the patient to meet certain standards. The nurse, in fact, may not approve of the patient's lifestyle or behavior patterns. However, with unconditional positive regard, the patient is accepted and respected for no other reason than that he or she is considered to be a worthwhile and unique human being.

Many psychiatric patients have very little self-respect. Sometimes lack of self-respect is related to the low self-esteem that accompanies illnesses such as clinical depression, and sometimes it is related to rejection and stigmatization by others. Recognition that they are unconditionally accepted and respected as unique, valuable individuals can elevate feelings of self-worth and self-respect. The nurse can convey an attitude of respect by

- Calling the patient by name (and title, if he or she prefers).
- Spending time with the patient.
- Allowing sufficient time to answer the patient's questions and concerns.
- Promoting an atmosphere of privacy during therapeutic interactions with the patient and during physical examination or therapy.

- Always being open and honest with the patient, even when the truth may be difficult to discuss.
- Listening to the patient's ideas, preferences, and opinions and making collaborative decisions concerning his or her care whenever possible.
- Striving to understand the motivation behind the patient's behavior regardless of how unacceptable it may seem.

Genuineness

The concept of **genuineness** refers to the nurse's ability to be open, honest, and "real" in interactions with the patient. To be real is to be aware of what one is experiencing internally and to allow the quality of this inner experience to be apparent in the therapeutic relationship. When one is genuine, there is *congruence* between what is felt and what is expressed (Raskin et al., 2014). The nurse who is genuine responds to the patient with truth and honesty rather than with responses he or she may consider more "professional" or ones that merely reflect the "nursing role."

Genuineness may call for a degree of *self-disclosure* on the part of the nurse. This is not to say that the nurse must disclose to the patient *everything* he or she is feeling or *all* personal experiences that relate to what the patient is going through. Indeed, care must be taken when using self-disclosure to avoid reversing the roles of nurse and patient. For example, when a patient tells the nurse, "I just get so upset when someone disrespects me; sometimes you have to smack someone to teach them a lesson," the nurse might respond, "I get upset by that, too. Let's talk about some different ways to respond to your anger rather than hitting someone." In this example, the nurse discloses a common feeling while maintaining a focus on the patient's need for problem-solving. When the nurse uses self-disclosure, a quality of "humanness" is revealed to the patient, creating a role for the patient to model in similar situations. The patient may then feel more comfortable revealing personal information to the nurse.

Most individuals have an uncanny ability to detect when others are artificial. When the nurse does not bring genuineness and respect to

the relationship, a reality basis for trust cannot be established. These qualities are essential to helping the patient actualize his or her potential within the nurse-patient relationship and for change and growth to occur (Raskin et al., 2014).

Empathy

Empathy is the ability to see beyond outward behavior and understand the situation from the patient's point of view. With empathy, the nurse can accurately perceive and comprehend the meaning and relevance of the patient's thoughts and feelings. The nurse must also be able to communicate this perception to the patient by attempting to translate words and behaviors into feelings.

It is not uncommon for the concept of empathy to be confused with that of **sympathy.** The major difference is that with *empathy* the nurse "accurately perceives or understands" what the patient is feeling and encourages the patient to explore these feelings. With *sympathy* the nurse actually "shares" what the patient is feeling and experiences a need to alleviate distress. Schuster (2000) stated:

> Empathy means that you remain emotionally separate from the other person, even though you can see the patient's viewpoint clearly. This is different from sympathy. Sympathy implies taking on the other's needs and problems as if they were your own and becoming emotionally involved to the point of losing your objectivity. To empathize rather than sympathize, you must show feelings but not get caught up in feelings or overly identify with the patient's and family's concerns. (p. 102)

Empathy is considered to be one of the most important characteristics of a therapeutic relationship. Accurate empathetic perceptions on the part of the nurse assist the patient in identifying feelings that may have been suppressed or denied. Positive emotions are generated as the patient realizes that he or she is truly understood by another. As the feelings surface and are explored, the patient learns aspects about the self of which he or she may have been unaware. This exploration contributes to the process of personal identification and the promotion of positive self-concept.

With empathy, while understanding the patient's thoughts and feelings, the nurse is able to maintain sufficient objectivity to allow the patient to achieve problem resolution with minimal assistance. With sympathy, the nurse feels what the patient is feeling, objectivity is lost, and the nurse may become focused on relief of personal distress rather than on helping the patient resolve the problem at hand. The following example describes a sympathetic response and an empathetic response to the same situation.

Example

Situation: BJ is a patient on the psychiatric unit with a diagnosis of persistent depressive disorder (dysthymia). She is 5 feet 5 inches tall and weighs 295 pounds. BJ has been overweight all her life. She is single, has no close friends, and has never had an intimate relationship with another person. It is her first day on the unit, and she is refusing to come out of her room. When she appeared for lunch in the dining room following admission, she was embarrassed when several of the other patients laughed out loud and called her "fatso."

Sympathetic response: Nurse: "I can certainly identify with what you are feeling. I've been overweight most of my life, too. I just get so angry when people act like that. They are so insensitive! It's just so typical of skinny people to act that way. You have a right to want to stay away from them. We'll just see how loud they laugh when *you* get to choose what movie is shown on the unit after dinner tonight."

Empathetic response: Nurse: "You feel angry and embarrassed by what happened at lunch today." As tears fill BJ's eyes, the nurse encourages her to cry if she feels like it and to express her anger at the situation. She stays with BJ but does not dwell on her *own* feelings about what happened. Instead, she focuses on BJ and what the client perceives are her most immediate needs at this time.

Rapport, trust, respect, genuineness, and empathy all are essential to forming therapeutic relationships, and they can be assets in social relationships, too. The primary differences between social and therapeutic relationships are that therapeutic relationships always remain focused on the health-care needs of the patient, are never used to address the nurse's personal needs, and progress through identified phases of development to help the patient solve health-related problems.

Phases of a Therapeutic Nurse-Patient Relationship

Psychiatric nurses use interpersonal relationship development as the primary intervention with patients in psychiatric-mental health settings. This activity is congruent with Peplau's (1962) identification of *counseling* as the major role of nursing in psychiatry. Sullivan (1953), from whom Peplau patterned her interpersonal theory of nursing, strongly believed that many emotional problems are closely related to difficulties with interpersonal relationships. With this concept in mind, the counseling role of the nurse in psychiatry becomes especially meaningful and purposeful—an integral part of the total therapeutic regimen.

The therapeutic interpersonal relationship is the means by which the nursing process is implemented. Through the relationship, problems are identified and resolution is sought. Tasks of the relationship have been categorized into four phases: (1) the preinteraction phase, (2) the orientation (introductory) phase, (3) the working phase, and (4) the termination phase. Although each phase is presented as specific and distinct from the others, there may be some overlap of tasks, particularly when the interaction is limited. The major nursing goals during each phase of the nurse-patient relationship are listed in Table 6–2.

The Preinteraction Phase

The preinteraction phase involves preparation for the first encounter with the patient. Tasks include the following:

- Obtaining available information about the patient from his or her chart, significant others, or other health-care team members. From this information, the initial assessment begins. The nurse may also become aware of personal responses to knowledge about the patient.
- Examining one's feelings, fears, and anxieties about working with a particular patient. For example, the nurse may have been reared in an alcoholic family and have ambivalent feelings about caring

for a patient who is dependent on alcohol. All individuals bring attitudes and feelings from prior experiences to the clinical setting. The nurse needs to be aware of how these preconceptions may affect his or her ability to care for individual patients.

The Orientation (Introductory) Phase

During the orientation phase, the nurse and patient become acquainted. Tasks include the following:

- Creating an environment for the establishment of trust and rapport.
- Establishing a contract for intervention that details the expectations and responsibilities of both nurse and patient.
- Gathering assessment information to build a strong patient database.
- Identifying the patient's strengths and limitations.
- Formulating nursing diagnoses.
- Setting goals that are mutually agreeable to the nurse and patient.
- Developing a plan of action that is realistic for meeting the established goals.
- Exploring feelings of both the patient and nurse in terms of the introductory phase.

TABLE 6–2 Phases of Relationship Development and Major Nursing Goals

PHASE	GOALS
1. Preinteraction	Explore self-perceptions
2. Orientation (introductory)	Establish trust Formulate contract for intervention
3. Working	Promote client change
4. Termination	Evaluate goal attainment Ensure therapeutic closure

Introductions are often uncomfortable, and the participants may experience some anxiety until a degree of rapport has been

established. Interactions may remain on a superficial level until anxiety subsides. Several interactions may be required to fulfill the tasks associated with this phase.

The Working Phase

The therapeutic work of the relationship is accomplished during this phase. Tasks include the following:

- Maintaining the trust and rapport established during the orientation phase.
- Promoting the patient's insight and perception of reality.
- Problem-solving using the model presented earlier in this chapter.
- Overcoming resistance behaviors on the part of the patient as the level of anxiety rises in response to discussion of painful issues.
- Continuously evaluating progress toward goal attainment.

Transference and Countertransference

Transference and countertransference are common phenomena that often arise during a therapeutic relationship.

Transference

Transference occurs when the patient unconsciously displaces (or "transfers") to the nurse feelings formed toward a person from his or her past (Sadock, Sadock, & Ruiz, 2015). These feelings may be triggered by something about the nurse's appearance or personality characteristics that remind the patient of another person. Transference can interfere with the therapeutic interaction when the feelings expressed include anger and hostility. Anger toward the nurse can be manifested by uncooperativeness and resistance to therapy.

Transference can also take the form of overwhelming affection for or excessive dependency on the nurse. The nurse is overvalued, and the patient forms unrealistic expectations of the nurse. When the nurse is unable to fulfill those expectations or meet the excessive dependency needs, the patient becomes angry and hostile.

Interventions for Transference Hilz (2013) states:

In cases of transference, the relationship does not usually need to be terminated, except when the transference poses a serious barrier to therapy or safety. The nurse should work with the patient in sorting out the past from the present, assist the patient into identifying the transference, and reassign a new and more appropriate meaning to the current nurse-patient relationship. The goal is to guide patients toward independence by teaching them to assume responsibility for their behaviors, feelings, and thoughts, and to assign the correct meanings to their relationships based on present circumstances instead of the past.

Countertransference

Countertransference refers to the nurse's behavioral and emotional responses to the patient in which the nurse transfers feelings (often unconscious) about past experiences or people onto the patient. These responses may be related to unresolved feelings toward significant others from the nurse's past, or they may be generated in response to transference feelings on the part of the patient. It is not easy to refrain from becoming angry when the patient is consistently antagonistic, to feel flattered when showered with affection and attention by the patient, or even to feel quite powerful when the patient exhibits excessive dependency on the nurse. These feelings can interfere with the therapeutic relationship when they initiate the following types of behaviors:

- The nurse overidentifies with the patient's feelings, as they remind him or her of problems from the nurse's past or present.
- The nurse and patient develop a social or personal relationship.
- The nurse begins to give advice or attempts to "rescue" the patient.
- The nurse encourages and promotes the patient's dependence.
- The nurse's anger engenders feelings of disgust toward the patient.
- The nurse feels anxious and uneasy in the presence of the patient.
- The nurse is bored and apathetic in sessions with the patient.
- The nurse has difficulty setting limits on the patient's behavior.
- The nurse defends the patient's behavior to other staff members.

The nurse may be completely unaware or only minimally aware of the countertransference as it is occurring (Hilz, 2013).

Interventions for Countertransference Hilz (2013) states:

> The relationship usually should not be terminated in the presence of countertransference. Rather, the nurse or staff member experiencing the countertransference should be supportively assisted by other staff members to identify his or her feelings and behaviors and recognize the occurrence of the phenomenon. It may be helpful to have evaluative sessions with the nurse after his or her encounter with the patient, in which both the nurse and other staff members (who are observing the interactions) discuss and compare the exhibited behaviors in the relationship.

The Termination Phase

Termination of the relationship may occur for a variety of reasons: the mutually agreed-on goals may have been reached, the client may be discharged from the hospital, or, in the case of a student nurse, the clinical rotation ends. Termination can be difficult for both the patient and nurse. The main task involves bringing a therapeutic conclusion to the relationship. The relationship concludes when the following occur:

- Progress has been made toward attainment of mutually set goals.
- A plan for continuing care or for assistance during stressful life experiences is mutually established by the nurse and patient.
- Feelings about termination of the relationship are recognized and explored. Both the nurse and patient may experience feelings of sadness and loss. The nurse should share his or her feelings with the patient. Through these interactions, the patient learns that it is acceptable to have these kinds of feelings at a time of separation. With this knowledge, the patient experiences growth during the process of termination. This is also a time when both nurse and patient may evaluate and summarize the learning that occurred as an outgrowth of their relationship.

CLINICAL PEARL When the patient feels sadness and loss, behaviors to delay termination may become evident. If the nurse experiences the same feelings, he or she may allow the patient's behaviors to delay termination. For therapeutic closure, the nurse must establish the reality of the separation and resist being manipulated into repeated delays by the patient.

Boundaries in the Nurse-Patient Relationship

A boundary indicates a border that determines the extent of acceptable limits. Many types of boundaries exist, such as the following:

- **Material boundaries:** These boundaries can be seen, such as fences that border land.
- **Social boundaries:** These are established within a culture and define how individuals are expected to behave in social situations.
- **Personal boundaries:** These are boundaries that individuals define for themselves. They include *physical distance boundaries,* or how closely individuals will allow others to enter their physical space, and *emotional boundaries,* or how much individuals choose to disclose of their most private and intimate selves to others.
- **Professional boundaries:** These boundaries limit and outline expectations for appropriate professional relationships with patients. "Professional boundaries are the spaces between a nurse's power and the patient's vulnerability" (National Council of State Boards of Nursing [NCSBN], 2018). Nurses must recognize that they have an imbalance of power with their patients because of their role and the patient information to which they have access. They must be consistently conscientious in avoiding any circumstance in which they might achieve personal gain within that relationship.

Concerns regarding professional boundaries are commonly related to the following issues:

- **Self-disclosure:** Self-disclosure on the part of the nurse may be appropriate when the information could therapeutically benefit the patient. It should never be undertaken to meet the nurse's needs.
- Individuals who are receiving care often feel indebted toward health-care providers. The British Columbia College of Professional Nurses (BCCPN, 2019) clarify in their practice standards that, although nurses do not generally exchange.pngts with patients, when it is deemed to have therapeutic intent, groups of nurses may accept a token.pngt, but significant.pngts should be returned or redirected. There is always a degree of clinical judgment necessary in deciding to accept or refuse a.pngt, including the appropriateness, the value, and the reason the.pngt is being offered. Cultural beliefs and values may also enter into the decision of whether to accept a.pngt from a patient. In some cultures, failure to do so would be interpreted as an insult (Pies, 2012). Accepting financial.pngts is never appropriate, but in some instances, nurses may be permitted to instead suggest a donation to a charity of the patient's choice. If acceptance of a small.pngt of gratitude is deemed appropriate, the nurse may choose to share it with other staff members who have been involved in the patient's care. In all instances, nurses should exercise professional judgment when deciding whether to accept a.pngt from a patient, and refusal of a.pngt should be done with sensitivity for the patient's feelings. Attention should be given to what the.pngt-giving means to the patient, as well as to institutional policy, the American Nurses Association (ANA) *Code of Ethics for Nurses,* and the ANA *Scope and Standards of Practice.*
- **Touch:** Nursing, by its very nature, involves touching patients. Touching is required to perform the therapeutic procedures involved in providing physical care. Caring touch is the touching of patients when there is no physical need to do so. Touching or hugging can be beneficial when it is implemented with therapeutic intent and patient consent. When using caring touch, make sure it

is appropriate, supportive, and welcomed (BCCPN, 2019). Caring touch may provide comfort or encouragement, but some vulnerable patients may misinterpret its meaning. In some cultures, touch is not considered acceptable unless the parties know each other very well. The nurse must be sensitive to these cultural nuances and aware when touch is crossing a personal boundary. Additionally, patients who are experiencing high levels of anxiety, suspiciousness, or psychosis may interpret touch as aggressiveness. These are times when touch should be avoided or considered with extreme caution.

- **Friendship or romantic association:** When a nurse is already acquainted with a patient, the relationship must move from a personal nature to professional. If the nurse is unable to accomplish this separation, he or she should withdraw from the nurse-patient relationship. Likewise, nurses must guard against personal relationships developing as a result of the nurse-patient relationship. Romantic, sexual, or otherwise intimate personal relationships are never appropriate between nurse and patient.

Certain warning signs indicate that professional boundaries of the nurse-patient relationship may be in jeopardy. These may include the following (Coltrane & Pugh, 1978):

- Favoring one patient's care over that of another
- Keeping secrets with a patient
- Changing dress style for working with a particular patient
- Swapping assignments to care for a particular patient
- Giving special attention or treatment to one client over others
- Spending free time with a patient
- Frequently thinking about the patient when away from work
- Sharing personal information or work concerns with the patient
- Receipt of.pngts or continued contact or communication with the patient after discharge

Boundary crossing can threaten the integrity of the nurse-patient relationship. Nurses must gain self-awareness and insight to recognize when professional integrity is compromised. Although some variables, such as the care setting, community influences,

patient needs, and the nature of therapy, affect how boundaries are delineated, “any actions that overstep the established boundaries to meet the needs of the nurse are boundary violations” (NCSBN, 2019).

Summary and Key Points

- Nurses who work in the psychiatric-mental health field use special skills, or “interpersonal techniques,” to assist patients in adapting to difficulties or changes in life experiences. Therapeutic nurse-patient relationships are goal oriented, and the problem-solving model is used to try to bring about some type of change in the patient’s life.
- The instrument for delivery of the process of interpersonal nursing is the therapeutic use of self, which requires that the nurse possess a strong sense of self-awareness and self-understanding.
- Hildegard Peplau identified seven nursing roles: stranger, resource person, teacher, leader, surrogate, technical expert, and counselor.
- Characteristics that enhance the achievement of a therapeutic relationship include rapport, trust, respect, genuineness, and empathy.
- Phases of a therapeutic nurse-patient relationship include the preinteraction phase, orientation (introductory) phase, working phase, and termination phase.
- Transference occurs when the patient unconsciously displaces (or “transfers”) to the nurse feelings formed toward a person from the past.
- Countertransference refers to the nurse’s behavioral and emotional response to the patient in which the nurse transfers feelings (often unconscious) about past experiences or people onto the patient. These responses may be related to unresolved feelings toward significant others from the nurse’s past, or they may be generated in response to transference feelings on the part of the patient.

- Types of boundaries include material, social, personal, and professional.
- Concerns associated with professional boundaries include self-disclosure,.pngt-giving, touch, and developing a friendship or romantic association.
- Boundary crossings can threaten the integrity of the nurse-patient relationship.

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Review Questions

1. Which of the following behaviors suggest a possible breach of professional boundaries? (Select all that apply.)
   a. The nurse repeatedly requests to be assigned to a specific patient.
   b. The nurse shares the details of her divorce with the patient.
   c. The nurse makes arrangements to meet the patient outside of the therapeutic environment.
   d. The nurse shares how she dealt with a similar difficult situation.
2. Which of the following tasks are associated with the orientation phase of relationship development? (Select all that apply.)
   a. Promoting the patient's insight and perception of reality
   b. Creating an environment for the establishment of trust and rapport
   c. Using the problem-solving model toward goal fulfillment
   d. Obtaining available information about the patient from various sources
   e. Formulating nursing diagnoses and setting goals
3. The nurse, who is an adult child of an alcoholic, is working with a client who abuses alcohol. The client has experienced a successful detoxification process and is beginning a rehabilitation program. He says to the nurse, "I'm not going to go to those

stupid AA meetings. They don't help anything." The nurse, whose father died of complications from alcoholism, responds with anger: "Don't you even care what happens to your children?" The nurse's response is an example of which of the following?

a. Transference
b. Countertransference
c. Self-disclosure
d. A breach of professional boundaries

4. The nurse is working with a client in the anger-management program. Which of the following identifies actions associated with the working phase of the therapeutic relationship?

a. The nurse and the client work together to identify goals for developing more adaptive ways to handle anger.
b. The client expresses a desire to continue in the anger management program after the goals have been met.
c. The nurse reviews the client's medical record and assesses his or her personal feeling about working with a client who abused their spouse.
d. The nurse assists the client in practicing various techniques to effectively manage anger and provides positive feedback when the client attempts to improve maladaptive behaviors.

5. When there is congruence between what is felt and what is expressed, the nurse is exhibiting which of the following characteristics?

a. Trust
b. Respect
c. Genuineness
d. Empathy

6. When the nurse shows unconditional acceptance of an individual as a worthwhile and unique human being, he or she is exhibiting which of the following characteristics?

a. Trust
b. Respect
c. Genuineness

d. Empathy

Clinical Judgment Questions

7. A client who is being discharged from an inpatient hospital stay has his wife bring a box of chocolates and a bouquet of flowers for his primary nurse. He presents these.pngts to the nurse, saying, “Thank you for taking care of me.” What is the most appropriate response by the nurse?

a. “I don’t accept.pngts from patients.”
b. “Thank you so much! It is so nice to be appreciated.”
c. “Thank you. I will share these with the rest of the staff.”
d. “Hospital policy forbids me to accept.pngts from patients.”

8. A client states to the nurse, “I worked as a secretary to put my husband through college, and as soon as he graduated, he left me. I hate him! I hate all men!” Which of the following is an empathetic response by the nurse?

a. “You are very angry now. This is a normal response to your loss.”
b. “I know what you mean. Men can be very insensitive.”
c. “I understand completely. My husband divorced me, too.”
d. “You are depressed now, but you will feel better in time.”

9. A client with schizophrenia appears very watchful of others and tells the nurse, “There are infiltrators everywhere and I think they are trying to kill me.” Which of these actions by the nurse would best promote development of trust with this client?

a. Touch the client’s shoulder and state, “I want you to feel safe here.”
b. State to the client, “I’m interested in hearing your thoughts. Would you like to talk more about this?”
c. Ask the client, “Why would you think such a thing?”
d. Tell the client, “It is an expectation that we will not talk about things that aren’t real.”

10. A client is being discharged from the inpatient psychiatric unit and states to his primary nurse, “Everyone abandons me and now you’re probably going to abandon me, too.” Which of these actions by the nurse best accomplishes termination of the therapeutic relationship?

a. Discuss the boundaries of this relationship and assist the client to explore his feelings.
b. Terminate the therapeutic relationship while exploring ways to remain connected as friends.
c. Provide discharge medication instructions and encourage the client to follow up with his physician.
d. Assure the client that he is not being abandoned and remind him that he can return to the unit in the future.

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