7 Therapeutic Communication

CORE CONCEPTS

Communication

Therapeutic Communication

CHAPTER OUTLINE

Objectives
Homework Assignment
What Is Communication?
The Impact of Preexisting Conditions
Nonverbal Communication
Therapeutic Communication Techniques
Nontherapeutic Communication Techniques
Active Listening
Motivational Interviewing
Process Recordings
Feedback
Summary and Key Points
Review Questions
Clinical Judgment Questions

KEY TERMS

density
distance
intimate distance
motivational interviewing
paralanguage
personal distance
public distance
social distance
territoriality

OBJECTIVES

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

1. Discuss the transactional model of communication.
2. Identify types of preexisting conditions that influence the outcome of the communication process.
3. Define *territoriality, density,* and *distance* as components of the environment.
4. Identify components of nonverbal expression.
5. Describe therapeutic and nontherapeutic verbal communication techniques.
6. Describe motivational interviewing as a communication strategy.
7. Describe active listening.
8. Discuss therapeutic feedback.

HOMEWORK ASSIGNMENT

Please read the chapter and answer the following questions:

1. A patient asks the nurse for advice about a personal situation, and the nurse responds, “What do you think you should do?” This is an example of what technique? Is it therapeutic or nontherapeutic?
2. “Just hang in there. Everything will be all right.” If the nurse makes this statement to a patient, it is an example of what technique? Is it therapeutic or nontherapeutic?
3. Why might it be more appropriate to conduct a patient interview in a conference room or interview room rather than in the patient’s room or nurse’s office?
4. Name the five elements of constructive feedback.
5. Write a one-page journal entry reflecting on things that friends or close relatives have told you characterize your style of communicating with others. How can you use this self-awareness to promote the development of therapeutic communication?

Development of the *therapeutic interpersonal relationship* is described in Chapter 6, “Relationship Development,” as the process by which nurses provide care for patients in need of psychosocial intervention. *Therapeutic use of self* was identified as the instrument for delivery of care. The focus of this chapter is on *techniques*—or, more specifically, *interpersonal communication techniques*—to facilitate delivery of that care.

In their classic work on therapeutic communication, Hays and Larson (1963) stated, “To relate therapeutically with a patient it is necessary for the nurse to understand his or her role and its relationship to the patient’s illness” (p. 1). They describe the role of the nurse as providing the patient with the opportunity to accomplish the following:

1. Identify and explore problems in relating to others.
2. Discover healthy ways of meeting emotional needs.

3. Experience a satisfying interpersonal relationship.

These goals are achieved through the use of interpersonal communication techniques (both verbal and nonverbal). The nurse must be aware of the therapeutic or nontherapeutic value of the communication techniques used with the patient because they are the tools of psychosocial intervention.

CORE CONCEPT

Communication
An interactive process of transmitting information between two or more entities.

What Is Communication?

It has been said that individuals "cannot *not* communicate." Every word spoken, every movement made, and every action taken or not taken gives a message to someone. Interpersonal communication is a *transaction* between the sender and the receiver. In the transactional model of communication, both participants simultaneously perceive each other, listen to each other, and are mutually involved in creating meaning in a relationship. The transactional model is illustrated in Figure 7-1.

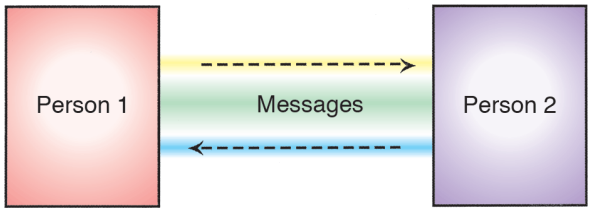

FIGURE 7-1 The Transactional Model of Communication.

The Impact of Preexisting Conditions

In all interpersonal transactions, the sender and receiver each bring certain preexisting conditions to the exchange that influence both the intended message and how it is interpreted. Examples of these

conditions include one's value system, internalized attitudes and beliefs, culture and religion, social status, gender, background knowledge and experience, and age or developmental level. The type of environment in which the communication takes place may also influence the outcome of the transaction. Figure 7-2 shows how these influencing factors are positioned on the transactional model.

Values, Attitudes, and Beliefs

Values, attitudes, and beliefs are learned ways of thinking. Children generally adopt the value systems and internalize the attitudes and beliefs of their parents. Children may retain this way of thinking into adulthood or develop a different set of attitudes and values as they mature.

Values, attitudes, and beliefs can influence communication in numerous ways. For example, prejudice is expressed verbally through negative stereotyping.

One's value system may be communicated with behaviors that are symbolic. For example, an individual who values youth may dress and behave in a manner that is characteristic of one who is much younger. Persons who value freedom and the American way of life may fly the U.S. flag in front of their homes each day. In each of these situations, a message is being communicated.

Culture and Religion

Communication has its roots in culture. Cultural mores, norms, ideas, and customs provide the basis for our way of thinking. Cultural values are learned and differ from society to society. For example, in some European countries (e.g., Italy, Spain, and France), men may greet each other with hugs and kisses; in the United States or Great Britain, shaking hands is a more culturally accepted style of greeting among men.

Religion can influence communication as well. Priests and ministers who wear clerical collars publicly communicate their mission in life. The collar may also influence the way in which others relate to them, either positively or negatively. Other symbolic

gestures, such as wearing a cross around the neck or hanging a crucifix on the wall, communicate an individual's religious beliefs.

Social Status

Studies of nonverbal indicators of social status or power have suggested that high-status persons are associated with gestures that communicate their higher-power position. For example, they use less eye contact, have a more relaxed posture, use louder voice pitch, place hands on hips more frequently, are "power dressers," have greater height, and maintain more distance when communicating with individuals considered to be of lower social status.

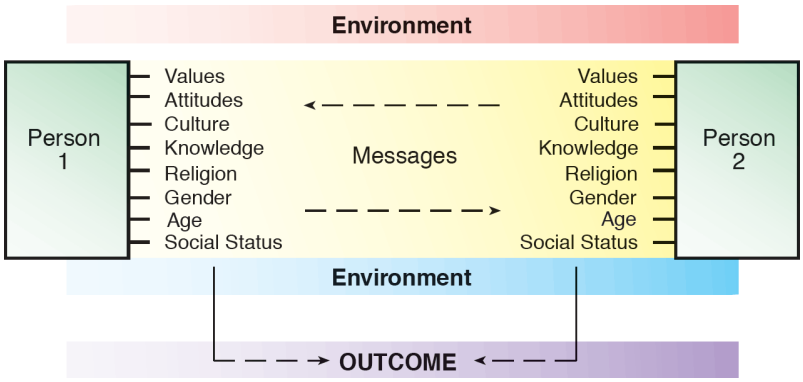

FIGURE 7-2 Factors influencing the Transactional Model of Communication.

Gender

Gender influences how individuals communicate. Most cultures have *gender signals* that are recognized as either masculine or feminine and provide a basis for distinguishing between members of each gender. Examples include differences in posture, both standing and sitting, between men and women in the United States. Men usually stand with thighs 10 to 15 degrees apart, the pelvis rolled back, and the arms slightly away from the body. Women often stand with legs close together, the pelvis tipped forward, and the arms close to the body. When sitting, men may lean back in the chair with legs apart or may rest the ankle of one leg over the knee of the other. Women tend to sit more upright in the chair with legs together, perhaps

crossed at the ankles, or one leg crossed over the other at thigh level.

Roles have historically been identified as either male or female. For example, in the United States masculinity typically has been communicated through roles such as husband, father, breadwinner, doctor, lawyer, or engineer. Traditional female roles include those of wife, mother, homemaker, nurse, teacher, or secretary.

Gender signals are changing in U.S. society as roles become less distinct. Behaviors once considered typically masculine or feminine may now be generally accepted in members of both genders. Words such as *nonbinary* communicate a desire by some individuals to diminish the distinction between genders and minimize the discrimination of either. Gender roles are changing as both women and men enter professions that were once dominated by members of the opposite gender.

Age or Developmental Level

Age influences communication, which is especially evident during adolescence. In their struggle to separate from parental confines and establish their own identity, adolescents generate a unique pattern of communication that changes from generation to generation. Words such as *dude, groovy, clueless, awesome, cool,* and *wasted* have had special meaning for certain generations of adolescents. The technological age has produced a whole new language for today's teenagers. Communication by text messaging and social media includes such acronyms as BRB ("be right back"), BFF ("best friends forever"), and MOS ("mom over shoulder").

Developmental influences on communication may relate to physiological alterations. One example is American Sign Language, the system of unique gestures used by many people who are deaf or hearing impaired. Individuals who are blind at birth never learn the subtle nonverbal gesticulations that accompany language, which can completely change the meaning of the spoken word.

Environment in Which the Transaction Takes Place

The place where communication occurs influences the outcome of the interaction. Some individuals who feel uncomfortable and refuse to speak during a group therapy session may be willing to discuss problems privately on a one-to-one basis with the nurse.

Territoriality, density, and **distance** are aspects of the environment that communicate messages. *Territoriality* is the innate tendency to own space. Individuals lay claim to areas around them as their own. When an interaction takes place in the territory "owned" by one or the other, it often influences communication. Interpersonal communication can be more successful if the interaction takes place in a "neutral" area. For example, with the concept of territoriality in mind, the nurse may choose to conduct the psychosocial assessment in an interview room rather than in his or her office or the patient's room.

Density refers to the number of people within a given environmental space. It has been shown to influence interpersonal interaction. Some studies indicate a correlation between prolonged high-density situations and certain behaviors, such as aggression, stress, criminal activity, hostility toward others, and a deterioration of mental and physical health.

Distance is the means by which various cultures use space to communicate. Hall (1966) identified four kinds of spatial interaction, or distances, that people maintain from each other in their interpersonal interactions and the kinds of activities in which people engage at these various distances. **Intimate distance** is the closest distance that individuals will allow between themselves and others. In mainstream American culture, this distance, which is restricted to intimate interactions, is 0 to 18 inches. **Personal distance** is approximately 18 to 40 inches and reserved for personal interactions, such as close conversations with friends or colleagues. **Social distance** is about 4 to 12 feet away from the body. Interactions at this distance include conversations with strangers or acquaintances, such as at a cocktail party or in a public building. A **public distance** is one that exceeds 12 feet. Examples include speaking in public or yelling to someone some distance away. This

distance is considered public space, and communicants are free to move about in it during the interaction.

Nonverbal Communication

Various studies have identified nonverbal communication as more reliable than verbal communication in expressing one's attitudes and feelings, and some describe it as the single most powerful way in which communication occurs (Healthfield, 2019). Some aspects of nonverbal expression were discussed in the previous section on preexisting conditions that influence communication. Other components of nonverbal communication include physical appearance and dress, body movement and posture, touch, facial expressions, eye behavior, and vocal cues or *paralanguage* (such as intonation, pitch, and speed; a more detailed description follows). These nonverbal messages vary from culture to culture.

Physical Appearance and Dress

Physical appearance and dress are part of the total nonverbal stimuli that influence interpersonal responses, and under some conditions, they are the primary determinants of such responses. Body coverings—both dress and hair—are manipulated by the wearer in a manner that conveys a distinct message to the receiver. Dress can be formal or casual, stylish or unkempt. Hair can be long or short, and even the presence or absence of hair conveys a message about the person. Other body adornments that are also considered potential communicative stimuli include tattoos, masks, cosmetics, badges, jewelry, and eyeglasses. Some jewelry worn in specific ways can give special messages (e.g., a gold band or diamond ring worn on the third finger of the left hand, a pin bearing Greek letters worn on the lapel, or the wearing of a ring inscribed with the insignia of a college or university). Some individuals convey a specific message with the total absence of any body adornment.

Body Movement and Posture

The way in which an individual positions his or her body communicates messages regarding self-esteem, gender identity, status, and interpersonal warmth or coldness. The individual whose posture is slumped, with the head and eyes pointed downward, conveys a message of low self-esteem. Specific ways of standing or sitting are considered to be either feminine or masculine within a defined culture. In the United States, to stand straight and tall with head high and hands on hips indicates a superior status over the person being addressed.

Reece and Whitman (1962) identified response behaviors that were used to designate individuals as either “warm” or “cold” persons. Individuals who were perceived as warm responded to others with a shift of posture toward the other person, a smile, direct eye contact, and hands that remained still. Individuals who responded to others with a slumped posture, by looking around the room, drumming fingers on the desk, and not smiling were perceived as cold.

Touch

Touch is a powerful communication tool. It can elicit both negative and positive reactions, depending on the people involved and the circumstances of the interaction. It is a very basic and primitive form of communication, and the appropriateness of its use is culturally determined.

Touch can be categorized according to the message communicated (Knapp & Hall, 2014):

- **Functional-professional:** This type of touch is impersonal and businesslike. It is used to accomplish a task.
  - Example: A tailor measuring a customer for a suit or a physician examining a patient
- **Social-polite:** This type of touch is still rather impersonal, but it conveys an affirmation or acceptance of the other person.
  - Example: A handshake
- **Friendship-warmth:** Touch at this level indicates a strong liking for the other person, a feeling that he or she is a friend.

- Example: Laying one's hand on the shoulder of another
- **Love-intimacy:** This type of touch conveys an emotional attachment or attraction for another person.
  - Example: Engaging in a strong, mutual embrace
- **Sexual arousal:** Touch at this level is an expression of physical attraction only.
  - Example: Touching another in the genital region

Some cultures encourage more touching of various types than do others. The nurse should understand the cultural meaning of touch before using this method of communication in specific situations. The best practice is to ask the patient's permission before using touch as an intervention.

Facial Expressions

Next to human speech, facial expression is the primary source of communication. Facial expressions reveal an individual's emotional state, such as happiness, sadness, anger, surprise, and fear. The face is a complex multimessage system. Facial expressions serve to complement and qualify other communication behaviors and at times even take the place of verbal messages. A summary of feelings associated with various facial expressions is presented in Table 7–1.

Eye Behavior

Eyes have been called the "windows of the soul." It is through eye contact that individuals view and are viewed by others in a revealing way, creating an interpersonal connection. In American culture, eye contact conveys a personal interest in the other person. Eye contact indicates that the communication channel is open, and it is often the initiating factor in verbal interaction between two people.

Eye behavior is regulated by social rules. These rules dictate where, when, for how long, and at whom we can look. Staring is often used to register disapproval of the behavior of another. People are extremely sensitive to being looked at, and if the gazing or staring behavior violates social rules, they often assign meaning to it, such as the following statement implies: "He kept staring at me, and I

began to wonder if I was dressed inappropriately or had mustard on my face!”

Vocal Cues or Paralanguage

Paralanguage is the gestural component of the spoken word. It consists of pitch, tone, and loudness of spoken messages; the rate of speaking; expressively placed pauses; and the emphasis assigned to certain words. These vocal cues greatly influence the way individuals interpret verbal messages. A normally soft-spoken individual whose pitch and rate of speaking increases may be perceived as being anxious or tense.

TABLE 7–1 **Summary of Facial Expressions**

FACIAL EXPRESSION	ASSOCIATED FEELINGS
NOSE	
Nostril flare	Anger; arousal
Wrinkling up	Dislike; disgust
LIPS	
Grin; smile	Happiness; contentment
Grimace	Fear; pain
Compressed	Anger; frustration
Canine-type snarl	Disgust
Pouted; frown	Unhappiness; discontented; disapproval
Pursing	Disagreement
Sneer	Contempt; disdain
BROWS	
Frown	Anger; unhappiness; concentration
Raised	Surprise; enthusiasm
TONGUE	
Stick out	Dislike; disagree
EYES	
Widened	Surprise; excitement
Narrowed; lids squeezed shut	Threat; fear
Stare	Threat
Stare, blink, then look away	Dislike; disinterest
Eyes downcast; lack of eye contact	Submission; low self-esteem
Eye contact (generally intermittent as opposed to a stare)	Self-confidence; interest

Sources: Cherry, K. (2019). Understanding body language and facial expressions. Retrieved from https://www.verywellmind.com/understand-body-language-and-facial-expressions-4147228; Simon, M. (2005). *Facial expressions: A visual reference for artists.* New York: Watson-Guptill.

Different vocal emphases can alter the interpretation of the message. Three examples follow:

1. "I felt **SURE** you would notice the change."
   Interpretation: I was **SURE** you would, but you didn't.
2. "I felt sure **YOU** would notice the change."
   Interpretation: I thought **YOU** would, even if nobody else did.
3. "I felt sure you would notice the **CHANGE."**
   Interpretation: Even if you didn't notice anything else, I thought you would notice the **CHANGE.**

Verbal cues play a major role in determining responses in human communication situations. *How* a message is verbalized can be as important as *what* is verbalized.

CORE CONCEPT

Therapeutic Communication
Caregiver verbal and nonverbal techniques that focus on the care receiver's needs and advance the promotion of healing and change. Therapeutic communication encourages the exploration of feelings and fosters understanding of behavioral motivation. It is nonjudgmental, discourages defensiveness, and promotes trust.

Therapeutic Communication Techniques

Hays and Larson (1963) identified a number of techniques to assist the nurse in interacting more therapeutically with patients. These are important "technical procedures" carried out by the nurse working in psychiatry, and they should serve to enhance the development of a therapeutic nurse-patient relationship. Table 7–2 includes a list of these techniques, a short explanation of their usefulness, and examples of each.

TABLE 7–2 **Therapeutic Communication Techniques**

TECHNIQUE	EXPLANATION/RATIONALE	EXAMPLES
Using silence	Silence encourages the patient to organize thoughts and put them into words and allows the patient time to think about the significance of events, thoughts, and feelings. Allowing the patient to break the silence often provides the nurse with important information about the patient's foremost concerns.	Patient: "My husband divorced me so I must be undesirable." Nurse: (silence) Patient: "You know, when I think about it, no matter what my husband does I always assume it's my fault or it's something wrong with me."
Accepting	Acceptance conveys an attitude of reception and regard.	"Yes, I understand what you said." Eye contact; nodding.
Giving recognition	Acknowledging and indicating awareness is better than complimenting, which reflects the nurse's judgment.	"Hello, Mr. J. I notice that you made a ceramic ashtray in OT." "I see you made your bed."
Offering self	Willingness to spend time with the patient and show interest on an unconditional basis helps to increase the patient's feelings of self-worth.	"I'll stay with you a while." "We can eat our lunch together." "I'm interested in hearing your thoughts about the group you just attended."
Giving broad openings	Broad openings allow the patient to direct the focus of the interaction and emphasizes the importance of the patient's role in the communication process.	"What would you like to talk about today?" "Is there anything you want to discuss?"
Offering general leads	General leads offer the patient encouragement to continue with minimal input from the nurse.	"Yes, I see." "Go on." "And after that?"
Placing the event in time or sequence	Encouraging the patient to identify the sequence of events and when they occurred in time facilitates	"What happened first?" "What happened next?" "Was this before or after …?" "When did this happen?"

	organizing one's thoughts about their experiences.	
Making observations	Verbalizing observations about a patient's behavior or appearance encourages the patient to develop awareness of how they are perceived by others and promotes exploration of issues that may be problematic.	"You appear sad today." "I notice you are pacing a lot." "I notice that when I ask you about whether you have thoughts of suicide you change the subject."
Encouraging description of perceptions	Asking the patient to verbalize his or her perceptions facilitates the patient's ability to develop awareness and understanding. For the patient experiencing hallucinations, it can facilitate both nurse's and patient's clarification about what the patient's perceptual experiences are communicating.	"Tell me more about the voices you said you are hearing." "What was it that increased your agitation during the group activity?" "Are these voices you hear directing you to take some action?"
Encouraging comparison	Asking the patient to compare similarities and differences in ideas, experiences, or interpersonal relationships helps the patient recognize life experiences that tend to recur and those aspects of life that are changeable.	"Was this episode similar to …?" "How does this compare with the time when …?" "What was your response the last time this situation occurred?"
Restating	Repeating the main idea of what the patient has said lets the patient know whether an expressed statement has been understood and gives him or her the chance to continue or to clarify if necessary.	Patient: "I can't study. My mind keeps wandering." Nurse: "You have trouble concentrating." Patient: "I can't take that new job. What if I can't do it?" Nurse: "You're afraid you will fail in this new position."
Reflecting	Questions and feelings are referred back to the patient so	Patient: "Don't you think I should tell my boss I'm not

	that the patient is empowered to actively engage in problem-solving rather than simply asking the nurse for advice.	putting up with that?" Nurse: "What do you think you should do?" Patient: "She makes me so upset!" Nurse: "So you're feeling angry at your boss?"
Focusing	Taking notice of a single idea or even a single word works especially well with a patient who is moving rapidly from one thought to another. However, focusing is very difficult for a patient with severe anxiety so in this case the nurse should not pursue focusing until the anxiety level decreases.	"Tell me more about this specific point."
Exploring	When the nurse hears the patient mention an issue or theme that seems relevant, the nurse asks the patient to explore this further. Exploring facilitates the patient's development of awareness and understanding about events, thoughts, and feelings. However, if the patient chooses not to disclose further information, the nurse should refrain from pushing or probing in an area that obviously creates discomfort.	"Please explain that situation in more detail." "Tell me more about that particular situation." "You mentioned feeling like no one cares about you. Tell me more about those feelings."
Seeking clarification and validation	Striving to explain vague or incomprehensible statements and searching for mutual understanding of what has been said facilitates and increases understanding for both patient and nurse.	"I'm not sure that I understand. Would you please explain?" "Tell me if my understanding agrees with yours." "Do I understand correctly that you said …?"

Presenting reality	When the patient has a misperception of the environment, the nurse defines reality by expressing his or her perception of the situation without challenging the patient's perceptions.	"I understand that the voices seem real to you, but I do not hear any voices." "I don't see anyone else in the room but you and me."
Voicing doubt	Expressing uncertainty as to the reality of the patient's perceptions is a technique often used with patients experiencing delusional thinking.	"It's difficult to believe that the President of the United States would be listening to all of your phone calls." "I find that hard to believe [or accept]." "That seems rather doubtful to me."
Verbalizing the implied	Putting into words what the patient has only implied or said indirectly is a technique that can be helpful with patients experiencing impaired verbal communication.	Patient: "I can't talk about this … you haven't been where I've been." Nurse: "Does it seem like no one could understand your thoughts and feelings unless they've had the same experiences you've had?" Patient: "I … I don't know where to begin." Nurse: "So it feels overwhelming to think about sharing the details of this experience."
Attempting to translate words into feelings	When the patient has difficulty identifying feelings or feelings are expressed indirectly, the nurse tries to "desymbolize" what has been said and to find clues to the underlying true feelings.	Patient: "I'm just an empty pit." Nurse: "It sounds like you are feeling hopeless, is that right?"
Formulating a	Encouraging the patient to	"What could you do differently

plan of action	identify a plan for behavior change promotes developing better coping skills.	if you are faced with this situation in the future?" "What are some steps you could take to manage your anger without punching someone?" "What is one thing you might be willing to try to decrease your anxiety instead of using alcohol?"

Sources: Adapted from Hays, J.S., & Larson, K.H. (1963). *Interacting with patients.* New York: Macmillan; Engard, B. (2019). 17 therapeutic communication techniques. Retrieved from https://online.rivier.edu/therapeutic-communication-techniques/; Sullivan, H.S. (1954). *The psychiatric interview.* New York, NY: Norton.

Nontherapeutic Communication Techniques

Several approaches are considered to be barriers to open communication between the nurse and patient. Hays and Larson (1963) identified a number of these techniques, which are presented in Table 7–3. Nurses should recognize and eliminate the use of these patterns in their relationships with patients. Avoiding these communication barriers will maximize the effectiveness of communication and enhance the nurse-patient relationship.

TABLE 7–3 **Nontherapeutic Communication Techniques**

TECHNIQUE	EXPLANATION/RATIONALE	EXAMPLES
Giving false reassurance	False reassurance conveys that the nurse already knows the outcome of a situation and minimizes the patient's expressed concerns. It may discourage the patient from further expression of feelings if he or she believes the feelings will be downplayed or ridiculed.	Patient: "My husband doesn't love me anymore. I think he wants a divorce." Nurse: "I'm sure he must still love you. Everything will be fine." **Better alternative:** "Tell me more about what's been happening in your relationship with your husband."
Rejecting	Refusing to consider or showing contempt for the patient's ideas or behavior may cause the patient to discontinue interaction with the nurse for fear of further rejection.	Patient: "Since I started taking this medication I can't be intimate with my girlfriend." Nurse: "Let's not talk about that right now." **Better alternative:** "Tell me more about what you mean by not being able 'to be intimate' with your girlfriend."
Approving or disapproving	Sanctioning or denouncing the patient's ideas or behavior implies that the nurse has the right to pass judgment on whether the patient's ideas or behaviors are "good" or "bad" and that the patient is expected to please the nurse. The nurse's acceptance of the patient is then seen as conditional depending on the patient's behavior.	"It's good that you confronted your wife about her behavior." "You shouldn't yell at your wife." **Better alternative:** "What happened after you confronted your wife in a loud voice?"
Agreeing or disagreeing	Indicating accord with or opposition to the patient's ideas or opinions implies that the nurse has the right to pass judgment on whether the	Patient: "I think my doctor doesn't care about me." Nurse: "I disagree. You shouldn't think that way." Or "I can't believe that's true."

	patient's ideas or opinions are "right" or "wrong." Agreement prevents the patient from later modifying his or her point of view without admitting error. Disagreement implies inaccuracy, provoking the need for defensiveness on the part of the patient.	**Better alternative:** "Tell me more about why you think your doctor doesn't care."
Giving advice	Telling the patient what to do or how to behave implies that the nurse knows what is best and nurtures the patient in the dependent role by discouraging independent thinking.	"You need to do deep breathing exercises when you become anxious." "You should stop drinking alcohol and start going to Alcoholics Anonymous meetings." **Better alternative:** "What do you think you should do?" or "Let's explore some options for solving this problem."
Probing	Persistent questioning of the patient and pushing for answers to issues the patient does not wish to discuss causes the patient to feel used and valued only for what information the nurse is seeking and may place the patient on the defensive.	"Why was your family angry with you?" "How many times did you receive poor evaluations before you got fired?" "How many girlfriends were you lying to?" **Better alternative:** The nurse should actively listen to the patient's response and discontinue the interaction at the first sign of discomfort.
Defending	Defending someone or something the patient has criticized minimizes or completely ignores the patient's concerns. Defending may cause the patient to think	"None of the nurses here would lie to you." "You have a very capable physician." "Your children want only what's best for you."

	the nurse is taking sides against him or her.	**Better alternative:** “Tell me more about these concerns you’ve expressed.”
Requesting an explanation	This technique involves asking the patient why he or she has certain thoughts, feelings, and behaviors. Asking “why” a patient did something or feels a certain way can be very intimidating and implies that the patient must defend his or her behavior or feelings.	“Why do you think people are out to get you?” “Why do you feel depressed?” “Why were you taking drugs?” **Better alternative:** “Describe what you were feeling just before that happened.”
Indicating the existence of an external source of power	Attributing the source of thoughts, feelings, and behavior to others or to outside influences encourages the patient to project blame for his or her thoughts or behaviors on others rather than accepting the responsibility personally.	“What made you go on a drinking binge?” “What made you say that you are a worthless person?” **Better alternative:** “What was happening just before you started binge drinking?” “What do you mean when you say you are ‘a worthless person’?”
Belittling or minimizing feelings	When the nurse minimizes the degree of the patient’s discomfort, a lack of empathy and understanding may be conveyed. When the nurse tells the patient to “cheer up” or “everybody feels that way,” the patient may feel that his or her concerns are insignificant or unimportant.	Patient: “I don’t even have the energy to go to work.” Nurse: “We’ve all felt like that at times. You’ve just got to ‘perk up’ and get moving.” **Better alternative:** “Tell me more about what you are feeling right now.”
Making stereotyped comments	Trite expressions are meaningless in a nurse-patient relationship. When the nurse uses meaningless expressions, it encourages a similar response from the patient.	“How are you?” “Hang in there.” “It’ll all work out.” **Better alternative:** Choose words, sentences, and nonverbal language that convey a sincere interest in encouraging the patient to

		share more about the patient's thoughts, feelings, and behaviors.
Using denial	Denying that a problem exists blocks discussion with the patient and avoids helping the patient identify and explore areas of difficulty.	Patient: "I have a problem interacting with people." Nurse: "You're doing fine." **Better alternative:** "Tell me more about that."
Interpreting	Interpreting attempts to tell the patient the meaning of his or her experience. Erroneous interpretations may leave the patient feeling that the nurse doesn't understand him or her, or that the nurse is being smug.	"What you really mean is…." "Your continued drinking is your way of avoiding discussing your anger over the divorce…." **Better alternative:** "Tell me more about what you're thinking (or feeling)."
Introducing an unrelated topic	When the nurse prematurely changes the subject, it conveys to the patient that the nurse does not want to discuss the original topic any further. This may occur in order to get to something that the nurse wants to discuss with the patient or to get away from a topic that he or she would prefer not to discuss.	"Patient: "I don't have anything to live for." Nurse: "How well did you sleep last night?" **Better alternative:** "Tell me more." Sometimes silence may be appropriate to convey that the nurse is willing to hear all of what the patient wants to say before moving on to a different topic.

Sources: Adapted from Hays, J.S., & Larson, K.H. (1963). *Interacting with patients.* New York: Macmillan; Engard, B. (2019). 17 therapeutic communication techniques. Retrieved from https://online.rivier.edu/therapeutic-communication-techniques/; Sullivan, H.S. (1954). *The psychiatric interview.* New York, NY: Norton.

Active Listening

To listen actively is to be attentive and demonstrate a desire to hear and understand what the patient is saying, both verbally and nonverbally. Attentive listening creates a climate in which the patient

can communicate. With active listening, the nurse communicates acceptance and respect for the patient, and trust is enhanced. A climate is established within the relationship that promotes openness and honest expression.

Several nonverbal behaviors have been designated as facilitative skills for attentive listening. Those listed here can be identified by the acronym SOLER:

S: Sit squarely facing the patient. This nonverbal cue gives the message that the nurse is there to listen and is interested in what the patient has to say.

O: Observe an open posture. Posture is considered "open" when arms and legs remain uncrossed. This nonverbal cue suggests that the nurse is open to what the patient has to say. With a closed position, the nurse can convey a somewhat defensive stance, possibly invoking a similar response in the patient.

L: Lean forward toward the patient. Leaning forward conveys to the patient that the nurse is involved in the interaction, interested in what is being said, and making a sincere effort to be attentive.

E: Establish eye contact. Eye contact, intermittently directed, is another behavior that conveys the nurse's involvement and willingness to listen to what the patient has to say. The absence of eye contact or the constant shifting of eye contact elsewhere in the environment gives the message that the nurse is not actually interested in what is being said.

CLINICAL PEARL Ensure that eye contact conveys warmth and is accompanied by smiling and intermittent nodding of the head and does not come across as staring or glaring, which can create intense discomfort in the patient.

R: Relax. Whether sitting or standing during the interaction, the nurse should communicate a sense of being relaxed and comfortable with the patient. Restlessness and fidgetiness communicate a lack of interest and may convey a feeling of discomfort that is likely to be transferred to the patient.

Motivational Interviewing

Patient-centered care has been identified as an important focus in the quest to improve the quality of nurse communication and therapeutic relationships with patients (Institute of Medicine, 2003). **Motivational interviewing** is an evidence-based, patient-centered style of communicating that promotes behavior change by guiding patients to explore their motivation for change and the advantages and disadvantages of their decisions. This style of communication incorporates active listening and verbal therapeutic communication techniques, but it is focused on what the patient wants (his or her current level of motivation) rather than on what the nurse thinks ***should*** be the next steps in behavior change. Motivational interviewing was originally developed for use with patients who have substance use disorders, primarily because this style of communication may decrease defensive responses. It has since gained widespread acceptance as a patient-centered communication strategy that promotes behavior change for patients with many different health-care issues. See “Real People, Real Stories” for an example of motivational interviewing described in a process recording format.

Process Recordings

Process recordings are written reports of verbal interactions with patients. They are verbatim accounts recorded by the nurse or student as a tool for improving interpersonal communication techniques. Process recording can take many forms but usually includes the verbal and nonverbal communication of both nurse and patient. The exercise provides a means for the nurse to analyze both the content and pattern of the interaction. Process recording, which is not considered documentation, is intended to be used as a learning tool for professional development. An example of one type of process recording is presented in Table 7–4.

Feedback

Feedback is a method of communication for helping the patient consider behavior modification by providing information about how he or she is perceived by others. Feedback can be useful to the patient if presented with objectivity by a trusted individual in a manner that discourages defensiveness.

Characteristics of useful feedback include the following:

- Feedback is descriptive rather than evaluative and focuses on the behavior rather than on the patient. Avoiding evaluative language reduces the need for the patient to react defensively. Objective descriptions allow patients to use the information in whatever way they choose. When the focus is on the person, rather than the behavior, patients may perceive that they are being judged as "good" or "bad.

Real People, Real Stories: A Sample of Motivational Interviewing in a Process Recording Format

The following is part of an interaction with Alan, incorporating motivational interviewing communication strategies in a process recording format. Learn more about Alan's story in the chapter on substance use disorders.

Interaction	Nurse's Thoughts and Feelings	Communication Technique/Evaluation
Karyn: You mentioned that you were at an event and you commented that you "needed a drink." Tell me more about what was happening. (SOLER) Alan: (nodding) I was perturbed. I felt like I was stuck at this event. There was supposed to be entertainment but it got canceled due to rain, and suddenly I noticed people were drinking and smoking. It brought back a lot of memories. (looks down)	I wasn't sure if Alan was willing to talk about this, but I thought it was important to facilitate his looking at his behavior in response to this experience. I was glad that Alan was open to discussing this experience, but he said so many things in this short statement that I had to be thoughtful about what to follow up on.	Technique: **Exploring** Evaluation: This approach was effective. Alan talked more about the event and was able to articulate some thoughts and feelings as well.
Karyn: So you felt perturbed and stuck…. (looking up, not making direct eye contact)	I was thinking that I don't usually explore feelings right off the bat because I believe it's better to help someone fully describe events and thoughts first (or at least it's less threatening). But I've interacted with Alan	Technique: **Reflecting** Evaluation: This technique was effective. Alan began to process his thoughts about why he might be feeling perturbed and stuck. I think I may have been not making direct eye contact because of my

	many times, he's been through rehab, sober for 7 years, and he's pretty comfortable talking about feelings.	perception that feelings can be a little more threatening for some people to talk about.
Alan: Yeah, but it didn't last long. Maybe it had something to do with the fact that there was nothing else going on and it seemed like the whole thing became about drinking. But then I just blacked it out.	My immediate thought was that I want to tell him to go to an AA meeting or call his sponsor, but I was trying to incorporate a motivational interviewing strategy, and that meant it would be better to help him explore his motivation for how to respond to this experience. I didn't know what he meant by "blacked it out," but I felt uncomfortable when he said that.	
Karyn: What do you mean when you say you blacked it out? (SOLER)	I thought this was an important statement to clarify because it might help him explore how he behaved in response to this event.	Technique: **Clarifying** Evaluation: Asking this question was effective. Alan talked at length about his thoughts and feelings.
Alan: (silent for several seconds) I	Alan seemed to be thinking a lot about	

do need to go back to an AA meeting. I mean, am I different than other people? I know there are other people out there that have to be struggling with the same kind of things. When I was in rehab, my mom and her boyfriend were always there taking me to meetings. My sister went, too … (silent for several more seconds) I know it's important (silence) … about 75% of the people I went to rehab with are back out there using again.	this and was responding with several different thoughts, so I felt like it was important to just use silence and facilitate his reflection. I thought Alan seemed to be genuinely considering a behavior change.	
Karyn: You said that you need to go back to a meeting and that they are important. Is it more helpful to go to meetings when you just start thinking about needing a drink, or do you think that meetings are only necessary after	I knew that Alan had not been going to meetings regularly for the last couple of years, even though he acknowledges their importance, so I wanted to know more about whether he thought behavior change (such as going to AA	Technique: **Restating, focusing** Evaluation: Restatement was effective. The way I chose to focus was probably leading Alan to choose the "right" answer, and that makes it harder to evaluate whether he is just telling me what I

you actually take a drink?	meetings) was necessary at this point.	want to hear or is really motivated. It might have been better to use the technique of formulating a plan of action.
Alan: Oh no, you've got to go long before you take that first drink. (silence) People told me when I was in rehab that they could tell I was really listening in meetings … the meetings were helpful … (silence), and I just reconnected with my sponsor on Facebook, so I need to get back to a meeting to see him.	Alan seemed like he was thinking about what is important to him, so I continued to remain silent to facilitate that process.	
Karyn: You've identified three reasons why you believe you need to go to a meeting: because they are helpful to you, because you want to find out if others are struggling with the same kinds of thoughts that you	I was thinking that he talks about needing to go to AA, and *I* was feeling anxious about wanting him to commit to that, but at the same time, I recognized that the motivation for change and commitment to a	Technique: **Summarizing, formulating a plan of action** Evaluation: I think the techniques were effective, although Alan may not be ready to formulate an action plan at present.

are, and because you need to reconnect with your sponsor. Do you have a plan in mind for how to follow through with that?	plan of action has to come from him.	
Alan: Well, I haven't done it yet. I guess I'm still just thinking about it.	I was appreciating his honesty and thinking that this is the challenge of motivational interviewing: accepting where the individual is at while continuing to explore and facilitate his or her motivations for behavior change.	

TABLE 7–4 **Sample Process Recording**

NURSE VERBAL (NONVERBAL)	PATIENT VERBAL (NONVERBAL)	NURSE'S THOUGHTS AND FEELINGS CONCERNING THE INTERACTION	ANALYSIS OF THE INTERACTION
Do you still have thoughts about harming yourself? (Sitting facing the patient; looking directly at patient.)	Not really. I still feel sad, but I don't want to die. (Looking at hands in lap.)	Felt a little uncomfortable. Always a hard question to ask.	Therapeutic. Asking a direct, closed-ended question about suicidal intent to elicit specific information.
Tell me what you were feeling before you took all the pills the other night. (Using SOLER techniques of active listening.)	I was just so angry! To think that my husband wants a divorce now that he has a good job. I worked hard to put him through college. (Fists clenched. Face and neck reddened.)	Beginning to feel more comfortable. Patient seems willing to talk, and I think she trusts me.	Therapeutic. Exploring. Delving further into the patient's feelings to help her better understand her experience.
You wanted to hurt him because you felt betrayed. (SOLER)	Yes! If I died, maybe he'd realize that he loved me more than that other woman. (Tears starting to well up in her eyes.)	Starting to feel sorry for her.	Therapeutic. Attempting to translate words into feelings to convey active listening.
Seems like a pretty drastic way to get your point across. (Small frown.)	I know. It was a stupid thing to do. (Wiping eyes.)	Trying hard to remain objective.	Nontherapeutic. Sounds disapproving. Better to have pursued patient's feelings.
How are you	I don't know. I still	Wishing there was	Therapeutic.

feeling about the situation now? (SOLER)	love him. I want him to come home. I don't want him to marry her. (Starting to cry again.)	an easy way to help relieve some of her pain.	Focusing on patient's current feelings to assess current mental status.
Yes, I can understand that you would like things to be the way they were before. (Offered patient a tissue.)	(Silence. Continues to cry softly.)	I'm starting to feel some anger toward her husband. Sometimes it's so hard to remain objective!	Therapeutic. Conveying empathy to support caring and connectedness.
What do you think are the chances of your getting back together? (SOLER)	None. He's refused marriage counseling. He's already moved in with her. He says it's over. (Wipes tears. Looks directly at nurse.)	Relieved to know that she isn't using denial about the reality of the situation.	Therapeutic. Reflecting on the patient's expressed feelings to encourage the patient to recognize and clarify their perceptions.
So how are you preparing to deal with this inevitable outcome? (SOLER)	I'm going to do the things we talked about: join a divorced women's support group, increase my job hours to full time, do some volunteer work, and call the suicide hotline if I feel like taking pills again. (Looks directly at nurse. Smiles.)	Positive feeling to know that she remembers what we discussed earlier and plans to follow through.	Therapeutic. Formulating a plan of action to set the foundation for problem-solving.
It won't be easy. But you have come a long way, and I feel you	Yes, I know I will have hard times. But I also know I have support, and	Feeling confident that the session has gone well; hopeful that the	Therapeutic. Presenting reality, making observations, and

have gained strength in your ability to cope. (Standing. Looking at patient. Smiling.)	I want to go on with my life and be happy again. (Standing, smiling at nurse.)	patient will succeed in what she wants to do with her life.	giving recognition to support patient's progress in problem-solving.

Example:

Descriptive and focused on behavior Evaluative	"Jessica was very upset in group today when you called her 'a cow' and laughed at her in front of the others." "You were very rude and inconsiderate to Jessica in group today."
Focus on patient	"You are a very insensitive person."

Example:

Specific	"You were talking to Joe when we were deciding on the issue. Now you want to argue about the outcome."
General	"You just don't pay attention."

- Feedback should be specific rather than general. Information that gives details about the patient's behavior is more effective than a generalized description in promoting behavior change.
- Feedback should be directed toward behavior that the patient can modify. To provide feedback about a characteristic or situation that the patient cannot change only provokes frustration.

Example:

Can modify	"I noticed that you did not want to hold your baby when the nurse brought her to you."
Cannot modify	"Your baby daughter is mentally retarded because you took drugs when you were pregnant."

- Feedback should impart information rather than offer advice. Giving advice fosters dependence and may convey the message to the patient that he or she is not capable of making decisions

and solving problems independently. It is the patient's right and privilege to be as self-sufficient as possible.

Example:

Imparting information	"There are various methods of assistance for people who want to lose weight, such as Overeaters Anonymous, Weight Watchers, regular visits to a dietitian, and the Physician's Weight Loss Program. You can decide what is best for you."
Giving advice	"You obviously need to lose a great deal of weight. I think the Physician's Weight Loss Program would be best for you."

- Feedback should be well timed. Feedback is most useful when given at the earliest appropriate opportunity following the specific behavior.

Example:

Prompt response	"I saw you hit the wall with your fist just now when you hung up the phone after talking to your mother."
Delayed response	"You need to learn some more appropriate ways of dealing with your anger. Last week after group I saw you pounding your fist against the wall."

Summary and Key Points

- Interpersonal communication is a transaction between the sender and the receiver.
- In all interpersonal transactions, the sender and receiver each bring certain preexisting conditions to the exchange that influence both the intended message and how it is interpreted.
- Examples of these preexisting conditions include one's value system, internalized attitudes and beliefs, culture and religion, social status, gender, background knowledge and experience, age or developmental level, and the type of environment in which the communication takes place.

- Nonverbal expression is a primary communication system in which meaning is assigned to various gestures and patterns of behavior.
- Some components of nonverbal communication include physical appearance and dress, body movement and posture, touch, facial expressions, eye behavior, and vocal cues or paralanguage.
- The meaning of the nonverbal components of communication is culturally determined.
- Therapeutic communication is an intentional process that applies both verbal and nonverbal techniques to focus on the care *receiver's* needs and advance the promotion of healing and change.
- Motivational interviewing is an evidence-based, patient-centered style of therapeutic communication that facilitates patients' exploration of their motivations for behavior change and guides patients to explore the advantages and disadvantages of their decisions.
- Nurses must be aware of and avoid techniques that are considered barriers to effective communication.
- Active listening is described as attentiveness to what the patient is saying through both verbal and nonverbal cues. Skills associated with active listening include sitting facing the patient, observing an open posture, leaning forward toward the patient, establishing eye contact, and being relaxed.
- Process recordings are written reports of verbal interactions with patients. They are used as learning tools for professional development.
- Feedback is a method of communication for helping the patient consider a modification of behavior.
- The nurse must be aware of the therapeutic or nontherapeutic value of the communication techniques used with the patient because they are the tools of psychosocial intervention.

Review Questions

1. A client who is angry with his psychiatrist says to the nurse, “He doesn’t know what he is doing. That medication isn’t helping a thing!” The nurse responds, “He has been a doctor for many years and has helped many people.” This is an example of what nontherapeutic technique?
   a. Rejecting
   b. Disapproving
   c. Probing
   d. Defending

2. A client says to the nurse, “I’ve been offered a promotion, but I don’t know if I can handle it.” The nurse replies, “You’re afraid you may fail in the new position.” This is an example of which therapeutic technique?
   a. Restating
   b. Making observations
   c. Focusing
   d. Verbalizing the implied

3. The environment in which communication takes place influences the outcome of the interaction. Which of the following are aspects of the environment that influence communication? (Select all that apply.)
   a. Territoriality
   b. Density
   c. Dimension
   d. Distance
   e. Intensity

4. The nurse says to a client, “You are being readmitted to the hospital. Why did you stop taking your medication?” What communication technique does this represent?
   a. Disapproving
   b. Requesting an explanation
   c. Disagreeing

d. Probing

5. A client who has been in rehabilitation for alcohol dependence returns from a visit to his home and tells the nurse, “We were having a celebration and I did have one drink, but it really wasn’t a problem.” The nurse notices that his breath smells of alcohol. Which of the following responses by the nurse demonstrates a motivational interviewing style of communication?
   a. “You are obviously not motivated to change, so perhaps we should discuss your discharge from the treatment program.”
   b. “You need to abstain from alcohol in order to recover, so let me talk to the doctor about the consequences of your behavior.”
   c. “Why would you destroy everything you’ve worked so hard to achieve?”
   d. “What do you mean when you say, ‘It really wasn’t a problem’?”

6. A client who has been diagnosed with schizophrenia and has been on medication for several months states, “I’m not taking that stupid medication anymore.” Which of the following responses by the nurse demonstrates a motivational interviewing style of communication?
   a. “Don’t you know that if you don’t take your medication you will never recover?”
   b. “Why won’t you cooperate with the treatment your doctor prescribed?”
   c. “Bill, the medication is not stupid.”
   d. “Tell me more about why you don’t want to take the medication.”

Clinical Judgment Questions

7. A client states, “I refuse to shower in this room. I must be very cautious. The FBI has placed a camera in here to monitor my every move.” Which of the following is the most therapeutic response?
   a. “That’s not true.”
   b. “I have a hard time believing that is true.”

c. “Surely you don’t really believe that.”
d. “I will help you search this room so that you can see there is no camera.”

8. A depressed client who has been unkempt and untidy for weeks comes to group therapy today wearing makeup and a clean dress with hair washed and combed. Which of the following responses by the nurse is most appropriate?
   a. “I see you have put on a clean dress and combed your hair.”
   b. “You look wonderful today!”
   c. “I’m sure everyone will appreciate that you have cleaned up for the group today.”
   d. “Now that you see how important it is, I hope you will do this every day.”

9. A client was involved in an automobile accident while under the influence of alcohol. She swerved her car into a tree and narrowly missed hitting a child on a bicycle. She is in the hospital with multiple abrasions and contusions. She is talking about the accident with the nurse. Which of the following statements by the nurse is most appropriate?
   a. “Now that you know what can happen when you drink and drive, I’m sure you won’t let it happen again.”
   b. “You know that was a terrible thing you did. That child could have been killed.”
   c. “I’m sure everything is going to be okay now that you understand the possible consequences of such behavior.”
   d. “How are you feeling about what happened?”

10. A client, who has been in the hospital for 3 weeks, has used Valium “to settle her nerves” for the past 15 years. She was admitted by her psychiatrist for safe withdrawal from the drug. She has passed the physical symptoms of withdrawal at this time but states to the nurse, “I don’t know if I will be able to make it without Valium after I go home. I’m already starting to feel nervous. I have so many personal problems.” Which is the most appropriate response by the nurse?

a. “Why do you think you need drugs to deal with your problems?”
b. “Everybody has problems, but not everybody uses drugs to deal with them. You’ll just have to do the best that you can.”
c. “Let’s explore some things you can do to decrease your anxiety without resorting to drugs.”
d. “Just hang in there. I’m sure everything is going to be okay.”

11. A client asks the nurse, “Do you think I should tell my husband about my affair with my boss?” Which is the most appropriate response by the nurse?
a. “What do you think would be best for you to do?”
b. “Of course you should. Marriage has to be based on truth.”
c. “Of course not. That would only make things worse.”
d. “I can’t tell you what to do. You have to decide for yourself.”

12. An adolescent who has just returned from group therapy is crying. She says to the nurse, “All the other kids laughed at me! I try to fit in, but I always seem to say the wrong thing. I’ve never had a close friend. I guess I never will.” Which is the most appropriate response by the nurse?
a. “What makes you think you will never have any friends?”
b. “You’re feeling pretty down on yourself right now.”
c. “I’m sure they didn’t mean to hurt your feelings.”
d. “Why do you feel this way about yourself?”

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8 The Nursing Process in Psychiatric-Mental Health Nursing

CORE CONCEPTS

Nursing Process

Assessment

Nursing Diagnosis

Outcomes

Planning

Implementation

Evaluation

CHAPTER OUTLINE

KEY TERMS

case management
case manager
concept mapping
critical pathways of care
Focus Charting®
interdisciplinary
managed care
Nursing Interventions Classification (NIC)
Nursing Outcomes Classification (NOC)
nursing process
PIE charting
problem-oriented recording

OBJECTIVES

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

1. Define *nursing process.*
2. Identify six steps of the nursing process, and describe nursing actions associated with each.
3. Describe the benefits of using nursing diagnosis.
4. Discuss the list of nursing diagnoses approved by NANDA International for clinical use and testing.
5. Define and discuss the use of case management and critical pathways of care in the clinical setting.
6. Apply the six steps of the nursing process in caring for a client in the psychiatric setting.
7. Describe the six areas of focus identified by The Institute of Medicine (and Quality and Safety Education for Nurses [QSEN] competencies) as critical to the improvement of health care.
8. Document patient care that validates use of the nursing process.

HOMEWORK ASSIGNMENT

Please read the chapter and answer the following questions:

1. Nursing outcomes (sometimes referred to as *goals*) are derived from the nursing diagnosis. Name two essential aspects of an acceptable outcome or goal.
2. Define *managed care.*
3. The American Nurses Association identifies certain interventions that may be performed only by psychiatric nurses in advanced practice. What are they?
4. In Focus Charting®, one item cannot be used as the focus for documentation. What is this item?

For many years, the **nursing process** has provided a systematic framework for the delivery of nursing care. This framework fulfills the requirement for a *scientific methodology* in order for nursing to be considered a profession.

This chapter examines the steps of the nursing process as they are set forth by the American Nurses Association (ANA) in *Nursing: Scope and Standards of Practice* (ANA, 2015). The landmark Institute of Medicine (now called the National Academy of Medicine) report (2003) identifies six critical areas of focus (patient-centered care, safety, teamwork and collaboration, evidence-based practice, informatics, and quality improvement) that are needed to shape the future and improve quality of health care. These six critical areas are incorporated as an important model for implementing nursing care. These areas have become known as quality and safety education for nurses (QSEN) competencies (Cronenwett et al., 2007). An explanation is provided for the implementation of case management and the critical pathways of care tool used with this methodology. A description of concept mapping is included, and documentation that validates the use of the nursing process is discussed.

The Nursing Process

Definition

The nursing process consists of six steps (Figure 8-1) and uses a problem-solving approach that is now accepted as nursing's scientific methodology. It is goal directed with the objective of quality patient care delivery.

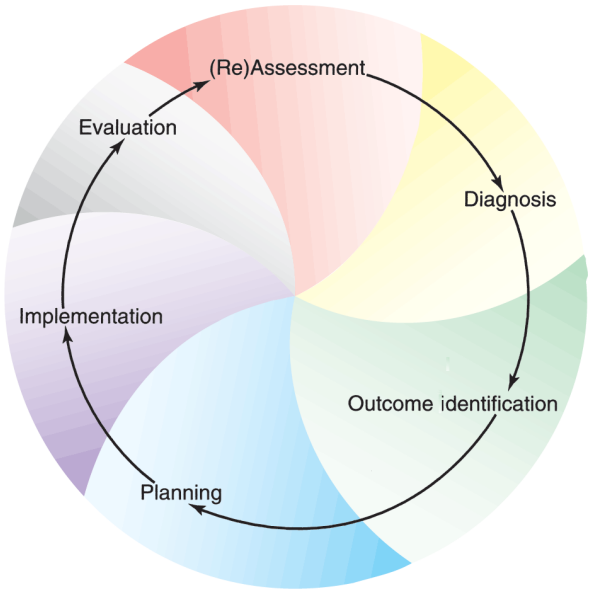

FIGURE 8-1 The ongoing nursing process.

The nursing process is dynamic, not static. It is an ongoing process that continues for as long as the nurse and patient have interactions directed toward change in the patient's physical or behavioral responses.

Standards of Practice

The ANA, in collaboration with the American Psychiatric Nurses Association (APNA) and the International Society of Psychiatric-Mental Health Nurses (ISPN) (2014), has delineated a set of standards that psychiatric-mental health nurses are expected to follow as they provide care for their patients. The ANA (2015) describes a *standard of practice* as an authoritative statement that is defined and promoted by the profession and that provides the foundation for evaluating quality of nursing practice. The nursing process is a critical thinking model that integrates professional standards of practice to assess, diagnose, identify outcomes, plan, implement, and evaluate nursing care. While the nursing process is often written as a detailed care plan in educational settings, it is rarely documented this way in practice. It is important for the nursing student to recognize that while he or she will not likely document care plans with the same measure of detail in practice, learning and using this critical thinking methodology is fundamental to nursing practice in any setting.

Following is a discussion of the standards of practice for psychiatric-mental health nurses as set forth by the ANA, APNA, and ISPN (2014). Many of these standards outline the registered nurse's role in each step of the nursing process and apply them to the psychiatric-mental health nurse. Three changes in the current standards of practice reflect issues and trends that have evolved more recently.

First, patients are now referred to as *health-care consumers.* This term reflects the trend toward patient-centered care and conceptualizing the nurse-patient relationship as a collaborative partnership.

Second, counseling interventions (performed by psychiatric-mental health registered nurses) are now differentiated from psychotherapy (performed by psychiatric-mental health *advanced practice* registered nurses). The third change, in "Standard 5G. Therapeutic Relationship and Counseling," adds the phrase "assisting healthcare consumers in their individual recovery journeys." This language supports the recovery model of intervention, a current trend focusing on a collaborative recovery process rather than health-care provider–prescribed treatment alone. (See Chapter 20, "The Recovery Model," for more information.)

CORE CONCEPT

Assessment

A systematic, dynamic process by which the registered nurse, through interaction with the patient, family, groups, communities, populations, and health-care providers, collects and analyzes data. Assessment may include the following dimensions: physical, psychological, sociocultural, spiritual, cognitive, functional abilities, developmental, economic, and lifestyle (ANA et al., 2014, p. 87).

Standard 1. Assessment

"The psychiatric-mental health registered nurse [PMH-RN] collects and synthesizes comprehensive health data that are pertinent to the healthcare consumer's health and/or situation" (ANA et al., 2014. p. 44).

In this first step, a database to determine the best possible patient care is established. Information for this database is gathered from a variety of sources, including interviews with the patient and family, observation of the patient and his or her environment, consultation with other health team members, review of the patient's records, and a nursing physical examination.

Many tools are available to assist the nurse in gathering this information. For example, a biopsychosocial assessment tool based on the stress-adaptation framework is included in Box 8-1. The primary focus of this assessment is to evaluate the patient's mental status and identify its impact on their safety and ability to function. Mental status evaluation can be either brief or extensive. An example of a simple and quick mental status evaluation is presented in Table 8–1. Sometimes the term *mental status assessment* is used to describe an assessment of the cognitive aspects of functioning, as is the case with tools such as Folstein's Mini-Mental State Evaluation (Folstein, Folstein, & McHugh, 1975). Likewise, the tool in Table 8–1 focuses strictly on a brief assessment of the cognitive aspects of mental functioning. In psychiatry and psychiatric-mental health nursing, mental status assessment assumes a much broader definition and includes assessment of mood, affect, behavior, relationships, speech, perceptual disturbances, insight, and judgment in addition to cognitive function. A comprehensive mental status assessment guide, with explanations and selected sample interview questions, is provided in Appendix C, Mental Status Assessment.

BOX 8–1 Nursing History and Assessment Tool

I. General Information

Patient name: _____ Allergies: _____

Room number: _____ Diet: _____

Doctor: _____ Height/weight: _____

Age: _____ Vital signs: TPR/BP _____

Sex: _____ Name and phone no. of significant other: _____

Race: _____

Dominant language: _____ City of residence: _____

Marital status: _____ Diagnosis (admitting & current): _____

Chief complaint: _____

_____

Conditions of admission:

Date: _____ Time: _____

Accompanied by: _____

Route of admission (wheelchair; ambulatory; cart): _____

Admitted from: _____

II. Predisposing Factors

A. *Genetic Influences*

1. Family configuration (use genograms):

Family of origin: Present family:

Family dynamics (describe significant relationships between family members): _____

_____

_____

_____

_____

2. Medical/psychiatric history: _____

a. Patient: _____

_____

_____

b. Family members: _____

_____

_____

3. Other genetic influences affecting present adaptation. This might include effects specific to gender, race, appearance, such as genetic physical defects, or any other factor related to genetics that is affecting the patient's adaptation that has not been mentioned elsewhere in this assessment.

B. *Past Experiences*

1. Cultural and social history:
   a. Environmental factors (family living arrangements, type of neighborhood, special working conditions):
   b. Health beliefs and practices (personal responsibility for health; special self-care practices):
   c. Religious beliefs and practices:
   d. Educational background:
   e. Significant losses/changes (include dates):
   f. Peer/friendship relationships:
   g. Occupational history:
   h. Previous pattern of coping with stress:
   i. Other lifestyle factors contributing to present adaptation:

C. *Existing Conditions*

1. Stage of development (Erikson):
   a. Theoretically:
   b. Behaviorally:
   c. Rationale:
2. Support systems:
3. Economic security:
4. Avenues of productivity/contribution:
   a. Current job status:
   b. Role contributions and responsibility for others:

III. Precipitating Event

Describe the situation or events that precipitated this illness/hospitalization: _____

_____

_____

IV. Patient's Perception of the Stressor

Patient's or family member's understanding or description of stressor/illness and expectations of hospitalization:

_____

_____

_____

V. Adaptation Responses

A. *Psychosocial*

1. Anxiety level (circle one of the 4 levels and check the behaviors that apply): Mild Moderate Severe Panic
   calm _____ friendly _____ passive _____ alert _____ perceives environment correctly _____ cooperative _____
   impaired attention _____ "jittery" _____ unable to concentrate _____ hypervigilant _____ tremors _____ rapid speech _____ withdrawn _____ confused _____ disoriented _____ fearful _____ hyperventilating _____ misinterpreting
   The environment (hallucinations or delusions) _____ depersonalization _____ obsessions _____ compulsions _____
   somatic complaints _____ excessive hyperactivity _____ other _____
   Judgment: Intact _____ Impaired _____
   Associated behaviors: _____
   Insight: Intact: _____ Impaired _____
   Associated patient statements: _____

2. Mood/affect (check as many as apply): happiness _____ sadness _____ dejection _____ despair _____ elation _____ euphoria _____ suspiciousness _____ apathy (little emotional tone) _____ anger/hostility _____

3. Level of self-esteem (check one): low _____ moderate _____ high _____
   Things patient likes about self _____
   _____
   Things patient would like to change about self _____
   _____
   Objective assessment of self-esteem: _____
   Eye contact _____
   General appearance _____
   _____
   Personal hygiene _____
   Participation in group activities and interactions with others _____
   _____

4. Stage and manifestations of grief (check one):
   Denial _____ Anger _____ Bargaining _____ Depression _____ Acceptance _____
   Describe the patient's behaviors and communication that are associated with this stage of grieving in response to loss or change.
   _____
   _____
   _____

5. Thought processes (check as many as apply): clear _____ logical _____ easy to follow _____ relevant _____ confused _____ blocking _____ delusional _____ rapid flow of thoughts _____ slowness in thought _____ suspicious _____

6 Memory
   Recent memory (check one): loss _____ intact _____ Remote memory (check one): loss _____ intact _____
   Other: _____
   _____

7. Communication patterns (check as many as apply): clear _____ coherent _____ slurred speech _____ incoherent _____ neologisms _____ loose associations _____ flight of ideas _____ aphasic _____ perseveration _____ rumination _____ tangential speech _____ loquaciousness _____ slow, impoverished speech _____ speech impediment (describe) _____
Other _____

8. Interaction patterns (describe patient's pattern of interpersonal interactions with staff and peers on the unit, e.g., manipulative, withdrawn, isolated, verbally or physically hostile, argumentative, passive, assertive, aggressive, passive-aggressive, other): _____

9. Reality orientation (check those that apply):
Oriented to: Time _____ Person _____
Place _____ Situation _____

10. Ideas of destruction to self/others (circle one)? Yes No
If yes, consider plan; available means _____

11. Nonsuicidal intent to self-injury (circle one)? Yes No

12. Intent to die (circle one)? Yes No
If yes, consider plan; available means: _____

13. Previous history of ideation and/or attempts (describe) _____

14. Intensity of current ideation (if present) _____

15. Other risk factors _____

16. Other warning signs

B. *Physiological*

1. Psychosomatic manifestations (describe any somatic complaints that may be stress-related):

2. Drug history and assessment:
Use of prescribed drugs:

Name	Dosage	Prescribed for	Results

Use of over-the-counter drugs:

Name	Dosage	Used for	Results

Medication Side Effects:
What symptoms is the client experiencing that may be attributed to current medication usage? _____

Use of street drugs or alcohol:

Name	Amount Used	How Often Used	When Last Used	Effects Produced

3. Pertinent physical assessments:
   a. Respirations: normal _____ labored _____
      Rate _____ Rhythm _____

   b. Skin: warm _____ dry _____ moist _____ cool _____ clammy _____ pink _____
      cyanotic _____ poor turgor _____ edematous _____
      Evidence of: rash _____ bruising _____ needle tracks _____ hirsutism _____
      loss of hair _____ other _____
      _____

   c. Musculoskeletal status: _____ weakness _____ tremors
      Degree of range of motion (describe limitations) _____
      _____
      Pain (describe) _____
      _____
      Skeletal deformities (describe) _____
      Coordination (describe limitations) _____

   d. Neurological status:
      History of (check all that apply): seizures _____ (describe method of control) _____
      _____
      headaches (describe location and frequency) _____
      fainting spells _____ dizziness _____
      tingling/numbness (describe location) _____

   e. Cardiovascular: B/P _____ Pulse _____
      History of (check all that apply):
      hypertension _____ palpitations _____
      heart murmur _____ chest pain _____
      shortness of breath _____ pain in legs _____
      phlebitis _____ ankle/leg edema _____
      numbness/tingling in extremities _____
      varicose veins _____

   f. Gastrointestinal:
      Usual diet pattern: _____
      Food allergies: _____
      Dentures? Upper _____ Lower _____
      Any problems with chewing or swallowing? _____
      Any recent change in weight? _____
      Any problems with: _____
      Indigestion/heartburn? _____
      Relieved by _____
      Nausea/vomiting? _____
      Relieved by _____

History of ulcers? _____
Usual bowel pattern _____
Constipation? _____ Diarrhea? _____
Type of self-care assistance provided for either of the above problems _____
_____

g. Genitourinary/Reproductive:
Usual voiding pattern _____
Urinary hesitancy? _____ Frequency? _____
Nocturia? _____ Pain/burning? _____
Incontinence? _____
Any genital lesions? _____
Discharge? _____ Odor? _____
History of sexually transmitted disease? _____
If yes, please explain: _____
_____
Any concerns about sexuality/sexual activity? _____
_____
Method of birth control used _____
Females:
Date of last menstrual cycle _____
Length of cycle _____
Problems associated with menstruation? _____
_____
Breasts: Pain/tenderness? _____
Swelling? _____ Discharge? _____
Lumps? _____ Dimpling? _____
Practice breast self-examination? _____
Frequency? _____
Males:
Penile discharge? _____
Prostate problems? _____

h.

Eyes:	**Yes**	**No**	**Explain**
Glasses?			
Contacts?			
Swelling?			
Discharge?			
Itching?			
Blurring?			
Double vision?			

i.

Ears	**Yes**	**No**	**Explain**
Pain?			
Drainage?			
Difficulty hearing?			
Hearing aid?			
Tinnitus?			

_____
_____

j. Altered laboratory values and possible significance:
_____
_____

Continued

k. Activity/rest patterns:
Exercise (amount, type, frequency) _____
_____
Leisure time activities: _____
_____
Patterns of sleep: Number of hours per night _____
Use of sleep aids? _____
Pattern of awakening during the night? _____
_____
Feel rested upon awakening? _____

l. Personal hygiene/activities of daily living:
Patterns of self-care: independent _____
Requires assistance with: mobility _____
hygiene _____
toileting _____
feeding _____
dressing _____
other _____
Statement describing personal hygiene and general appearance _____
_____
_____
_____

m. Other pertinent physical assessments: _____
_____
_____

VI. Summary of Initial Psychosocial/Physical Assessment:

Knowledge Deficits Identified:

Nursing Diagnoses Indicated:

CORE CONCEPT

Nursing Diagnosis

Clinical judgments about individual, family, or community experiences/responses to actual or potential health problems/life processes. A nursing diagnosis provides the basis for selection of nursing interventions to achieve outcomes for which the nurse has accountability (NANDA International [NANDA-I], 2018).

Standard 2. Diagnosis

"The psychiatric-mental health registered nurse analyzes the assessment data to determine diagnoses, problems, and areas of focus for care and treatment, including level of risk" (ANA et al., 2014, p. 46).

In the second step, data gathered during the assessment are analyzed. Diagnoses and potential problem statements are formulated and prioritized. Diagnoses are congruent with available and accepted classification systems (e.g., *NANDA International Nursing Diagnoses: Definitions and Classification).*

TABLE 8–1 **Brief Mental Status Evaluation**

AREA OF MENTAL FUNCTION EVALUATED	EVALUATION ACTIVITY
Orientation to time	"What year is it?" "What month is it?" "What day is it?" (3 points)
Orientation to place	"Where are you now?" (1 point)
Attention and immediate recall	"Repeat these words now: bell, book, and candle." (3 points) "Remember these words, and I will ask you to repeat them in a few minutes"
Abstract thinking	"What does this mean: No use crying over spilled milk." (3 points)
Recent memory	"Say the 3 words I asked you to remember earlier." (3 points)
Naming objects	Point to eyeglasses and ask, "What is this?" Repeat with 1 other item (e.g., calendar, watch, pencil). (2 points possible)
Ability to follow simple verbal command	"Tear this piece of paper in half and put it in the trash container." (2 points)
Ability to follow simple written command	Write a command on a piece of paper (e.g., TOUCH YOUR NOSE), give the paper to the patient, and say, "Do what it says on this paper." (1 point for correct action)
Ability to use language correctly	Ask the patient to write a sentence. (3 points if sentence has a subject, a verb, and valid meaning)
Ability to concentrate	"Say the months of the year in reverse, starting with December." (1 point each for correct answers from November through August; 4 points possible)
Understanding spatial relationships	Instruct patient to draw a clock, put in all the numbers, and set the hands on 3 o'clock. (clock circle = 1 pt; numbers in correct sequence = 1 pt; numbers placed on clock correctly = 1 pt; two hands on the clock = 1 pt; hands set at correct time = 1 pt; 5 points possible)

Scoring: 30–21 = normal; 20–11 = mild cognitive impairment; 10–0 = severe cognitive impairment (scores are not absolute and must be considered within the comprehensive diagnostic assessment).

Sources: Folstein, M.F., Folstein, S.E., & McHugh, P.R. (1975). Mini-mental state: A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research, 12*(3), 189-198; Kaufman, D.M., & Zun, L. (1995). A quantifiable, brief mental status examination for emergency patients. *Journal of Emergency Medicine, 13*(4), 440-456; Kokman, E., Smith, G.E., Petersen, R.C., Tangalos, E., & Ivnik, R.C. (1991). The short test of mental status: Correlations with standardized psychometric testing. *Archives of Neurology, 48*(7), 725-728; Pfeiffer, E. (1975). A short portable mental status questionnaire for the assessment of organic brain deficit in elderly patients. *Journal of the American Geriatric Society, 23*(10), 433-441.

CORE CONCEPT

Outcomes

Patient behaviors and responses that are collaboratively agreed upon, measurable, desired results of nursing interventions.

Standard 3. Outcomes Identification

"The psychiatric-mental health registered nurse identifies expected outcomes and the healthcare consumer's goals for a plan individualized to the healthcare consumer or to the situation" (ANA et al., 2014, p. 48).

Expected outcomes are derived from the diagnosis. They must be measurable and include a time estimate for attainment. They must be realistic for the patient's

capabilities, and they are most effective when formulated cooperatively by the interdisciplinary team members, the patient, and significant others.

Nursing Outcomes Classification

The **Nursing Outcomes Classification (NOC)** is a comprehensive, standardized classification of patient outcomes developed to evaluate the effects of nursing interventions (Moorhead et al., 2018). The outcomes have been linked to NANDA International (NANDA-I) diagnoses and the **Nursing Interventions Classification (NIC).** NANDA-I, NIC, and NOC represent all domains of nursing and can be used together or separately (Moorhead & Dochterman, 2012). Each of the NOC outcomes has a label name, a definition, a list of indicators to evaluate patient status in relation to the outcome, and a five-point Likert scale to measure patient status (Moorhead et al., 2018).

Standard 4. Planning

"The psychiatric-mental health registered nurse develops a plan that prescribes strategies and alternatives to assist the healthcare consumer in attainment of expected outcomes" (ANA et al., 2014, p. 50).

The care plan is individualized to the patient's mental health problems, condition, or needs and is developed in collaboration with the patient, significant others, and interdisciplinary team members if possible. For each diagnosis identified, the most appropriate interventions are selected based on current psychiatric-mental health nursing practice, standards, relevant statutes, and research evidence. Patient education and necessary referrals are included. Priorities for delivery of nursing care are determined based on safety needs and the patient's risk for harm to self or others. Elements of the plan should be prioritized with input from the patient, the family, and others as appropriate (ANA et al., 2014).

Nursing Interventions Classification

NIC is a comprehensive, standardized language describing treatments that nurses perform in all settings and specialties (Butcher, Bulechek, Dochterman, & Wagner, 2018). NIC includes both physiological and psychosocial interventions as well as those for illness treatment, illness prevention, and health promotion. NIC interventions are comprehensive, supported by research, and reflect current clinical practice. They were developed inductively based on existing practice.

Each NIC intervention has a definition and a detailed set of activities that describe what a nurse does to implement the intervention. The use of standardized language is thought to enhance continuity of care and facilitate communication among nurses and between nurses and other providers.

Standard 5. Implementation

The psychiatric-mental health registered nurse implements the identified plan (ANA et al., 2014, p. 52).

Interventions selected during the planning stage are executed, taking into consideration the nurse's level of practice, education, and certification. The care plan serves as a blueprint for delivery of safe, ethical, and appropriate interventions.

Documentation of interventions also occurs at this step in the nursing process. Several specific interventions, discussed below, are included among the standards of psychiatric-mental health clinical nursing practice (ANA et al., 2014).

Standard 5A. Coordination of Care

"The psychiatric-mental health registered nurse coordinates care delivery" (ANA et al., 2014, p. 54).

 One of the QSEN competencies, teamwork and collaboration, is consistent with this ANA standard of practice. In order for the nurse to coordinate care, it is critical that he or she understands the roles of other health care team members and develops strategies for effectively collaborating to meet the patient's needs.

Standard 5B. Health Teaching and Health Promotion

"The psychiatric-mental health registered nurse employs strategies to promote health and a safe environment" (ANA et al., 2014, p. 55).

Standard 5C. Consultation

"The psychiatric-mental health advanced practice registered nurse provides consultation to influence the identified plan, enhance the abilities of other clinicians to provide services for healthcare consumers, and effect change" (ANA et al., 2014, p. 57).

Standard 5D. Prescriptive Authority and Treatment

"The psychiatric-mental health advanced practice registered nurse uses prescriptive authority, procedures, referrals, treatments, and therapies in accordance with state and federal laws and regulations" (ANA et al., 2014, p. 58).

Standard 5E. Pharmacological, Biological, and Integrative Therapies

"The psychiatric-mental health registered nurse incorporates knowledge of pharmacological, biological, and complementary interventions with applied clinical skills to restore the healthcare consumer's health and prevent further disability" (ANA et al., 2014, p. 59).

Standard 5F. Milieu Therapy

"The psychiatric-mental health registered nurse provides, structures, and maintains a safe, therapeutic, recovery-oriented environment in collaboration with healthcare consumers, families, and other healthcare clinicians" (ANA et al., 2014, p. 60).

Several models have been developed to identify what constitutes a therapeutic environment. These models are discussed in greater detail in Chapter 11, "Milieu Therapy—The Therapeutic Community." Incorporation of the health-care environment and the community of clients, their families, and health-care providers is a unique aspect of treatment for the client with a psychiatric-mental health disorder.

Standard 5G. Therapeutic Relationship and Counseling

“The psychiatric-mental health registered nurse (PMH-RN) uses the therapeutic relationship and counseling interventions to assist healthcare consumers in their individual recovery journeys by improving and regaining their previous coping abilities, fostering mental health, and preventing mental disorder and disability” (ANA et al., 2014, p. 62).

As mentioned previously, therapeutic relationship and counseling interventions are part of the role of registered nurses practicing in psychiatric-mental health settings. These are basic psychoeducational and problem discussion interventions and are differentiated from psychotherapy that requires advanced practice education and competency.

Standard 5H. Psychotherapy

The psychiatric-mental health advanced practice registered nurse conducts individual, couples, group, and family psychotherapy using evidence-based psychotherapeutic frameworks and the nurse-client therapeutic relationship (ANA et al., 2014, p. 63).

CORE CONCEPT

Evaluation

The process of determining the health-care consumer’s progress toward attainment of expected outcomes, and the effectiveness of the registered nurse’s care and interventions (ANA et al., 2014, p. 88).

Standard 6. Evaluation

“The psychiatric-mental health registered nurse evaluates progress toward attainment of expected outcomes” (ANA et al., 2014, p. 65).

During the evaluation step, the nurse measures the success of the interventions in meeting the outcome criteria. The patient’s response to treatment is documented, validating use of the nursing process in the delivery of care. The diagnoses, outcomes, and plan of care are reviewed and revised as determined by the evaluation.

Why Nursing Diagnosis?

The concept of nursing diagnosis is not new. For centuries, nurses have identified specific patient responses for which nursing interventions were used to improve quality of life. However, because of the limitations imposed by their licensure, nurses have lacked autonomy in provision of care. Nurses assisted physicians as required and performed a group of specific tasks that were considered within their scope of responsibility. Formal identification of nursing diagnoses, however, affirms those aspects of nursing practice that are within their scope of practice *and* independently directed or implemented.

The term *diagnosis* in relation to nursing first began to appear in the literature in the early 1950s. The formalized organization of the concept, however, was initiated in 1973 with the convening of the First Task Force to Name and Classify Nursing Diagnoses. The Task Force of the National Conference Group on the Classification of Nursing

Diagnoses formed during this conference was charged with the task of identifying and classifying nursing diagnoses.

Also in the 1970s, the ANA began to write standards of practice around the steps of the nursing process, of which nursing diagnosis is an inherent part. This format encompassed both the general and specialty standards outlined by the ANA.

From this progression, a policy statement that includes a definition of nursing was published in 1980. The ANA defined nursing as "the diagnosis and treatment of human responses to actual or potential health problems" (ANA, 2010). This definition has been expanded to describe more appropriately nursing's commitment to society and the profession. The ANA (no date) currently describes nursing as follows:

> Beyond the time-honored reputation for compassion and dedication lies a highly specialized profession, which is constantly evolving to address the needs of society. From ensuring the most accurate diagnoses to the ongoing education of the public about critical health issues; nurses are indispensable in safeguarding public health…. Through the critical thinking exemplified in the nursing process, nurses use their judgment to integrate objective data with subjective experience of a patient's biological, physical and behavioral needs. This ensures that every patient, from city hospital to community health center; state prison to summer camp, receives the best possible care regardless of who they are, or where they may be.

Decisions regarding professional negligence are made based on the standards of practice defined by the ANA and the individual state nurse practice acts. Many states have incorporated the steps of the nursing process, including nursing diagnosis, into the scope of nursing practice described in their nurse practice acts. When this is the case, it is the legal duty of the nurse to show that the nursing process and nursing diagnosis were accurately implemented in the delivery of nursing care.

NANDA-I evolved from the original 1973 task force to name and classify nursing diagnoses. The major purpose of NANDA-I is to "to develop, refine and promote terminology that accurately reflects nurses' clinical judgments" (2018, p. 29). The list of NANDA-I-approved diagnoses is by no means all-inclusive. In an effort to maintain a common language within nursing and encourage clinical testing, most of the nursing diagnoses used in this text are taken from the 2018–2020 list approved by NANDA-I. However, in a few instances, nursing diagnoses that have been retired by NANDA-I for various reasons will continue to be used because of their appropriateness and suitability in describing specific behaviors.

The use of nursing diagnosis affords a degree of autonomy that historically has been lacking in the practice of nursing. Nursing diagnosis describes the patient's unhealthy or potentially unhealthy responses, facilitating the prescription of interventions and establishment of parameters for outcome criteria based on aspects of practice that are unique to nursing. The ultimate benefit is to the patient, who receives effective and consistent nursing care based on knowledge of the problems that he or she is experiencing and of the most beneficial nursing interventions to resolve them.

Nursing Case Management

The concept of **case management** evolved with the advent of diagnosis-related groups (DRGs) and shorter hospital stays. Case management is a model of care delivery that can result in improved client care. In this model, clients are assigned a manager who negotiates with multiple providers to obtain diverse services. This type of health-care delivery process serves to decrease fragmentation of care while striving to contain cost of services.

Case management in the acute care setting aims to organize client care through an episode of illness so that specific clinical and financial outcomes are achieved within an allotted time frame. Commonly, the allotted time frame is determined by the established protocols for length of stay as defined by the DRGs.

Case management has been shown to be an effective method of treatment for individuals with severe and persistent mental illness. This type of care strives to improve functioning by assisting the individual in solving problems, improving work and socialization skills, promoting leisure-time activities, and enhancing overall independence.

Ideally, case management incorporates concepts of care at the primary, secondary, and tertiary levels of prevention. Various definitions have emerged and should be clarified, as follows.

Managed care refers to a strategy employed by purchasers of health services who make determinations about various services to maintain quality and control costs. In a managed care program, individuals receive health care based on need as assessed by coordinators of the providership. Managed care exists in many settings, including (but not limited to):

- Insurance-based programs
- Employer-based medical providerships
- Social service programs
- The public health sector

Managed care may exist in virtually any setting in which a private or government-based organization is responsible for payment of health-care services for a group of people. Examples of managed care are health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

Case management, the method used to achieve managed care, is the actual coordination of services required to meet the needs of a client within the fragmented health-care system. Case management strives to help at-risk clients prevent avoidable episodes of illness while controlling health-care costs for the consumer and third-party payers. Types of clients who benefit from case management include (but are not limited to):

- The frail elderly
- Individuals with developmental disabilities
- Individuals with physical disabilities
- Individuals with mental disabilities
- Individuals with long-term, medically complex problems who require multifaceted, costly care (e.g., high-risk infants, those who are HIV positive or who have AIDS, and transplant clients)

- Individuals who are severely compromised by an acute episode of illness or an acute exacerbation of a severe and persistent illness (e.g., schizophrenia)

The **case manager** is responsible for negotiating with multiple health-care providers to obtain a variety of services for the client. Nurses are exceptionally qualified to serve as case managers. The very nature of nursing, which incorporates knowledge about the biological, psychological, and sociocultural aspects related to human functioning, makes nurses highly appropriate for this role. Several years of experience as a registered nurse are usually required for employment as a case manager. Some case management programs prefer advanced practice registered nurses who have experience working with the specific populations for whom the service will be rendered. The American Nurses Credentialing Center (ANCC) offers an examination for nurses to become board certified in nursing case management.

Critical Pathways of Care

Critical pathways of care (CPCs) may be used as the tools for provision of care in a case management system. A critical pathway is an abbreviated care plan that provides guidelines for goal achievement within a designated length of stay. A sample CPC is presented in Table 8–2. Only one nursing diagnosis is used in this sample, but a comprehensive CPC may have nursing diagnoses for several individual problems and incorporates the responsibilities of other team members as well.

TABLE 8–2 **Sample Critical Pathway of Care for Patient in Alcohol Withdrawal**

Estimated Length of Stay: 7 Days—Variations from designated pathway should be documented in progress notes

NURSING DIAGNOSES AND CATEGORIES OF CARE	TIME DIMENSION	GOALS AND/OR ACTIONS	TIME DIMENSION	GOALS AND/OR ACTIONS	TIME DIMENSION	DISCHARGE OUTCOME
Risk for injury related to CNS agitation					Day 7	Patient shows no evidence of injury obtained during ETOH withdrawal
Referrals	Day 1	Psychiatrist Assess need for: Neurologist Cardiologist Internist			Day 7	Discharge with follow-up appointments as required
Diagnostic studies	Day 1	Blood alcohol level Drug screen (urine and blood) Chemistry profile Urinalysis Chest x-ray ECG	Day 4	Repeat selected diagnostic studies as necessary		
Additional assessments	Day 1 Day 1–5 Ongoing Ongoing	VS q4h I&O Assess withdrawal symptoms: tremors, nausea/vomiting, tachycardia, sweating, high blood pressure, seizures, insomnia, hallucinations	Day 2–3 Day 6 Day 4	VS q8h if stable DC I&O Marked decrease in objective withdrawal symptoms	Day 4–7 Day 7	VS bid; remain stable Discharge; absence of objective withdrawal symptoms
Medications	Day 1 Day 2 Day 1–6 Day 1–7	*Librium 200 mg in divided doses Librium 160 mg in divided doses Librium prn Maalox pc & hs **Note*: Some physicians may	Day 3 Day 4	Librium 120 mg in divided doses Librium 80 mg in divided doses	Day 5 Day 6 Day 7	Librium 40 mg Discontinue Librium Discharge; no withdrawa symptoms

	elect to use Serax or Tegretol in the detoxification process				
Patient education		Day 5	Discuss goals of AA and need for outpatient therapy	Day 7	Discharge with information regarding AA attendance or outpatient treatment

AA, Alcoholics Anonymous; bid, twice a day; DC, discontinue; ECG, electrocardiogram; ETOH, alcohol; hs, bedtime; I&O, intake and output; pc, after meals; prn, as needed; q4h, every 4 hours; q8h, every 8 hours; VS, vital signs.

CPCs are intended to be used by the entire interdisciplinary team, which may include a nurse, case manager, clinical nurse specialist, social worker, psychiatrist, psychologist, dietitian, occupational therapist, recreational therapist, chaplain, and others. The team decides what categories of care are to be performed, by what date, and by whom. Each member of the team is then expected to carry out his or her functions according to the timeline designated on the CPC.

 Unlike a nursing care plan, CPCs have the benefit of describing what an episode of care will look like when implemented by team members in collaboration with one another. Clarity about how *team members collaborate* is important not only for providing efficient patient care but also for improving *quality* and *safety.*

As a case manager, the nurse is ultimately responsible for ensuring that each assignment is carried out. If variations occur in any of the categories of care, the rationale must be documented in the progress notes. For example, with the sample CPC presented in Table 8–2, the nurse case manager may admit the client into the detoxification center. The nurse contacts the psychiatrist to inform him or her of the admission. The psychiatrist performs additional assessments to determine whether other consultations are required and writes the orders for the initial diagnostic work-up and medication regimen. Within 24 hours, the interdisciplinary team meets to decide on other categories of care, complete the CPC, and make individual care assignments from the CPC. This particular sample CPC relies heavily on nursing care of the client through the critical withdrawal period. However, other problems for the same client, such as imbalanced nutrition, impaired physical mobility, or spiritual distress, may involve other members of the team to a greater degree. Each member of the team stays in contact with the case manager regarding individual assignments. Ideally, team meetings are held daily or every other day to review progress and modify the plan as required.

CPCs can be standardized, as they are intended to be used with uncomplicated cases. A CPC can be viewed as protocol for clients who have specific problems for which a designated outcome can be predicted.

Applying the Nursing Process in the Psychiatric Setting

Based on the definition of *mental health* stated in Chapter 2, "Mental Health and Mental Illness: Historical and Theoretical Concepts," the nurse's role in psychiatry is to help the patient successfully adapt to stressors in the environment. Goals are directed toward changes in thoughts, feelings, and behaviors that are age appropriate and congruent with local and cultural norms.

Therapy in the psychiatric setting is very often team oriented, or **interdisciplinary.** Therefore, it is important to delineate nursing's involvement in the treatment regimen. Nurses are valuable members of the team. Having progressed beyond the role of custodial caregiver in the psychiatric setting, they provide defined services within the scope of nursing practice. Nursing diagnosis is helping to define these nursing boundaries, providing a degree of autonomy and professionalism that has for so long been unrealized.

For example, a newly admitted client with the medical diagnosis of schizophrenia may be demonstrating the following behaviors:

- Inability to trust others
- Hearing voices
- Refusal to interact with staff and peers
- Fear of failure
- Poor personal hygiene

From these assessments, the treatment team may determine that the client has the following problems:

- Paranoid delusions
- Auditory hallucinations
- Social withdrawal
- Developmental regression

Team goals would be directed toward the following:

- Reducing suspiciousness
- Terminating auditory hallucinations
- Increasing feelings of self-worth

From this team treatment plan, nursing may identify the following nursing diagnoses:

- Disturbed sensory perception, auditory (evidenced by hearing voices)*
- Disturbed thought processes (evidenced by delusions)*
- Low self-esteem (evidenced by fear of failure and social withdrawal)
- Self-care deficit (evidenced by poor personal hygiene)

Nursing diagnoses are prioritized according to life-threatening potential. Maslow's hierarchy of needs is an appropriate model to follow when prioritizing nursing diagnoses. In this instance, Disturbed sensory perception (auditory) is identified as the priority nursing diagnosis because the patient may be hearing voices that command him or her to harm self or others. Psychiatric nursing, regardless of the setting—hospital (inpatient or outpatient), office, home, community—is goal-directed care. The

goals (or expected outcomes) are patient-oriented, measurable, and focused on problem resolution (if this is realistic) or on a more short-term outcome (if resolution is unrealistic). For example, in the previous situation, expected outcomes for the identified nursing diagnoses might be as follows:

The patient:

- Demonstrates trust in one staff member within 3 days
- Verbalizes understanding that the voices are not real (not heard by others) within 5 days
- Completes one simple craft project within 5 days
- Takes responsibility for self-care and performs activities of daily living independently by time of discharge

Nursing's contribution to the interdisciplinary treatment regimen will focus on establishing trust on a one-to-one basis (thus reducing the level of anxiety that may be promoting hallucinations), giving positive feedback for small day-to-day accomplishments to build self-esteem, and assisting with and encouraging independent self-care. These interventions describe *independent nursing* actions and goals that are evaluated apart from, while also being directed toward the achievement of, the *team's* treatment goals.

In this manner of collaboration with other team members, nursing provides a unique service based on sound knowledge of psychopathology, scope of practice, and legal implications of the role. Although implementing physician's orders is acknowledged as an important aspect of nursing care, nursing interventions that enhance the achievement of the overall goals of treatment are important contributions as well. The nurse who administers a medication prescribed by the physician to decrease anxiety may also choose to stay with the anxious patient and offer reassurance of safety and security, thereby providing an independent nursing action that is distinct from, yet complementary to, the medical treatment.

Concept Mapping*

Concept mapping is a diagrammatic teaching and learning strategy that allows students and faculty to visualize interrelationships between medical diagnoses, nursing diagnoses, assessment data, and treatments. The concept map is a diagram of client problems and interventions. Compared with the commonly used column format care plans, concept map care plans are more succinct. They primarily serve to enhance critical-thinking skills and clinical reasoning ability by creating a holistic picture of various patient problems and their interconnectedness to one another.

The nursing process is foundational to developing and using the concept map care plan, just as with all types of nursing care plans. Patient data are collected and analyzed, nursing diagnoses are formulated, outcome criteria are identified, nursing actions are planned and implemented, and the success of the interventions in meeting the outcome criteria is evaluated.

The concept map care plan may be presented in its entirety on one page, or the assessment data and nursing diagnoses may appear in diagram format on one page,

with outcomes, interventions, and evaluation written on a second page. Alternatively, the diagram may appear in circular format, with nursing diagnoses and interventions branching off the “patient” in the center of the diagram. Or, it may begin with the “patient” at the top of the diagram, with branches emanating downward in a linear fashion.

Whatever format is chosen to visualize the concept map, the diagram should reflect the nursing process in a stepwise fashion, beginning with the patient and his or her reason for needing care, nursing diagnoses with subjective and objective clinical evidence for each, nursing interventions, and outcome criteria for evaluation.

Figure 8-2 presents one example of a concept map care plan. It is assembled for the hypothetical patient with schizophrenia discussed in the previous section, “Applying the Nursing Process in the Psychiatric Setting.” Different colors may be used in the diagram to designate various components of the care plan. Connecting lines are drawn between components to indicate relationships. For example, there may be a relationship between two nursing diagnoses (e.g., between the nursing diagnoses of Pain or Anxiety and Disturbed sleep pattern). A line between these nursing diagnoses should be drawn to show the relationship.

Concept map care plans permit viewing the “whole picture” without generating a great deal of paperwork. Because they reflect the steps of the nursing process, concept map care plans also are valuable guides for documentation of patient care. Doenges, Moorhouse, and Murr (2019) note that traditional care plans fail to clarify how all the patient’s identified needs are related, so the user may not develop a holistic view. The concept map clarifies those linkages. Whether these care-planning strategies are used for learning or in actual practice, both the concept map and traditional care plan are useful tools for developing and visualizing the critical-thinking process that goes into planning patient care.

Documentation of the Nursing Process

Equally as important as using the nursing process in the delivery of care is documenting its use in writing. Some contemporary nursing leaders advocate that with solid standards of practice and procedures in place within the institution, nurses need only chart when there has been a deviation in the care as outlined by that standard. This method of documentation, known as *charting by exception,* is not widely accepted, as many legal decisions are still based on the precept that “if it was not charted, it was not done.”

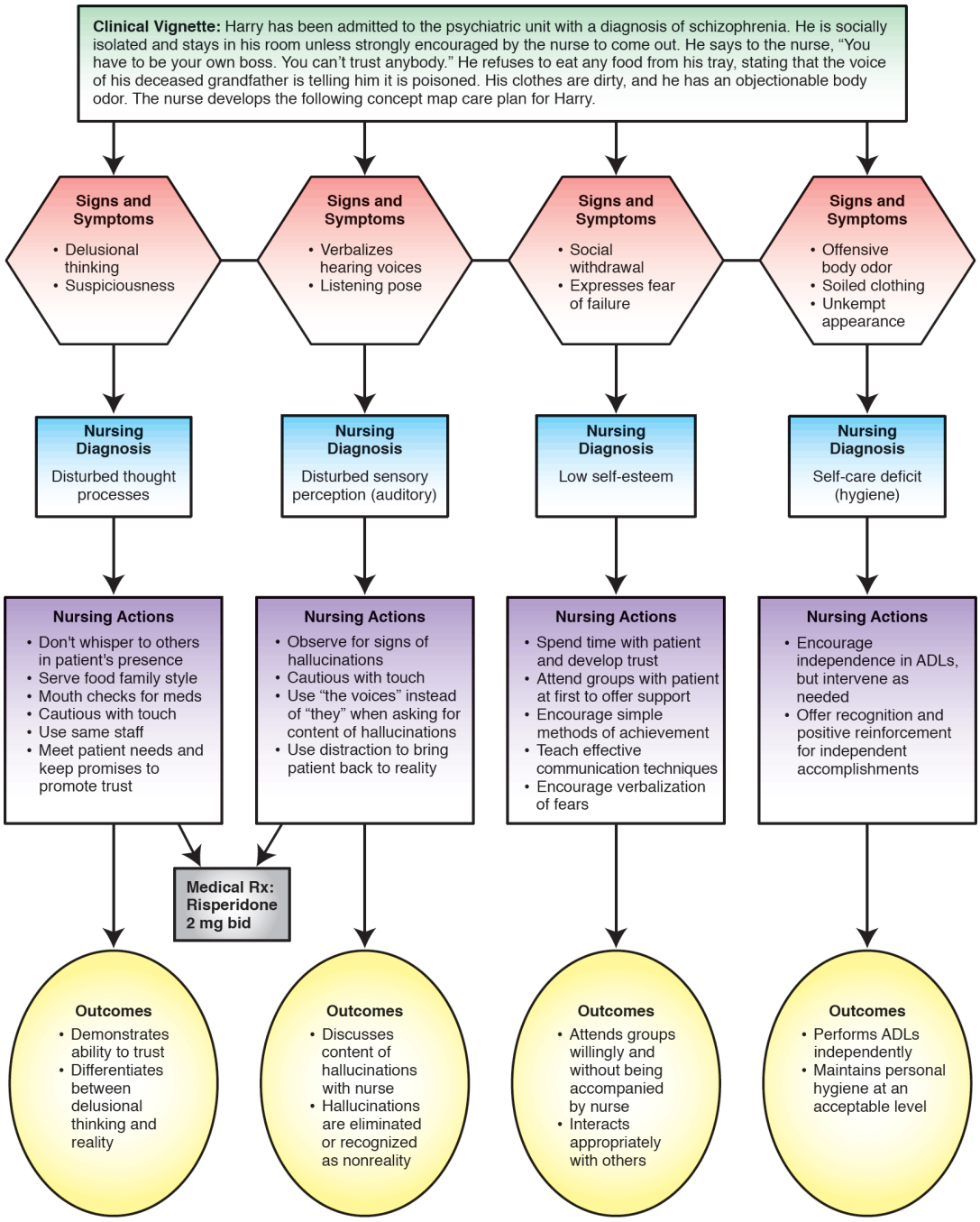

FIGURE 8-2 Example of a concept map care plan for a patient with schizophrenia.

Because nursing process and diagnosis are mandated by nurse practice acts in some states, documentation of their use is considered evidence in those states when determining certain cases of negligence by nurses. Some health-care organization accrediting agencies also require that the nursing process be reflected in the delivery of care.

A variety of documentation methods can be used to reflect use of the nursing process in the delivery of nursing care. Three examples are presented here: problem-

oriented recording (POR); Focus Charting®; and the problem, intervention, evaluation (PIE) system of documentation. Electronic health records (EHRs) have become a primary vehicle for documentation of patient care, and many rely heavily on preset menus and checklists. However, the various methods of documentation described below remain an important model for critical thinking about the essential aspects to be included in communicating and documenting patient care. These methods can be incorporated in electronic nurses' notes when there is an opportunity or need to provide additional documentation in the EHR.

Problem-Oriented Recording

Problem-oriented recording, based on a list of problems, follows the subjective, objective, assessment, plan, implementation, and evaluation (SOAPIE) format. When used in nursing, the problems (nursing diagnoses) are identified on a written plan of care, with appropriate nursing interventions described for each. Documentation written in the SOAPIE format includes the following:

S = Subjective data: Information gathered from what the patient, family, or other source has said or reported

O = Objective data: Information gathered through direct observation by the person performing the assessment; may include a physiological measurement such as blood pressure or a behavioral response such as affect

A = Assessment: The nurse's interpretation of the subjective and objective data

P = Plan: The actions or treatments to be carried out (may be omitted in daily charting if the plan is clearly explained in the written nursing care plan and no changes are expected)

I = Intervention: Those nursing actions that were actually carried out

E = Evaluation: Evaluation of the problem following nursing intervention (some nursing interventions cannot be evaluated immediately, so this section may be optional)

Table 8–3 shows how POR corresponds to the steps of the nursing process. The following is an example of a three-column documentation in the POR format.

Example

DATE/TIME	PROBLEM	PROGRESS NOTES
9-12-2020 1000	SOCIAL ISOLATION	**S:** States he does not want to sit with or talk to others; "they frighten me." **O:** Stays in room alone unless strongly encouraged to come out; no group involvement; at times listens to group conversations from a distance but does not interact; some hypervigilance and scanning noted **A:** Inability to trust; panic level of anxiety; delusional thinking **P:** Facilitate patient's ability to attend group activities with manageable level of anxiety **I:** Initiated trusting relationship by spending time alone with the patient; discussed his feelings regarding interactions with others; discussed strategies for decreasing anxiety; accompanied patient to group activities; provided positive feedback for voluntarily participating in assertiveness training **E:** Patient stayed throughout the group activity. Reported using deep breathing exercises to decrease anxiety and felt "a little less anxious." Identified that the assertive communication techniques he learned are something he needs to use more often.

TABLE 8–3 Validation of the Nursing Process With Problem-Oriented Recording

PROBLEM-ORIENTED RECORDING	WHAT IS RECORDED	NURSING PROCESS
S and O (Subjective and Objective data)	Verbal reports to, and direct observation and examination by, the nurse	Assessment
A (Assessment)	Nurse's interpretation of S and O	Diagnosis and outcome Identification
P (Plan) (Omitted in charting if written plan describes care to be given)	Description of appropriate nursing actions to resolve the identified problem	Planning
I (Intervention)	Description of nursing actions actually carried out	Implementation
E (Evaluation)	A reassessment of the situation to determine results of nursing actions implemented	Evaluation

Focus Charting

Another type of documentation that reflects use of the nursing process is **Focus Charting®.** Focus Charting differs from POR in that the main perspective has been changed from "problem" to "focus," and a data, action, and response (DAR) format has replaced SOAPIE.

Lampe (1985) suggested that a focus for documentation can be any of the following:

- Nursing diagnosis
- Current patient concern or behavior
- Significant change in the patient status or behavior
- Significant event in the patient's therapy

The focus cannot be a medical diagnosis. The documentation is organized in the format of DAR. These categories are defined as follows:

D = Data: Information that supports the stated focus or describes pertinent observations about the patient

A = Action: Immediate or future nursing actions that address the focus, and evaluation of the present care plan along with any changes required

R = Response: Description of patient's responses to any part of the medical or nursing care

Table 8–4 shows how Focus Charting corresponds to the steps of the nursing process.

The following is an example of a three-column documentation in the DAR format.

Example

DATE/TIME	PROBLEM	PROGRESS NOTES
9-12-2020 1000	Social isolation related to mistrust, panic anxiety, delusions	**D:** States he does not want to sit with or talk to others; they "frighten" him; stays in room alone unless strongly encouraged to come out; no group involvement; at times listens to group conversations from a distance, but does not interact; some hypervigilance and scanning noted **A:** Initiated trusting relationship by spending time alone with patient; discussed his feelings regarding interactions with others; accompanied patient to group activities; provided positive feedback for voluntarily participating in assertiveness training **R:** Cooperative with therapy; still acts uncomfortable in the presence of a group of people; accepted positive feedback from nurse

TABLE 8–4 **Validation of the Nursing Process With Focus Charting**

FOCUS CHARTING	WHAT IS RECORDED	NURSING PROCESS
D (Data)	Information that supports the stated focus or describes pertinent observations about the patient	Assessment
Focus	A nursing diagnosis; current patient concern or behavior; significant change in patient status; significant event in the patient's therapy (*Note*: If outcome appears on written care plan, does not need to be repeated in daily documentation unless a change occurs.)	Diagnosis and outcome identification
A (Action)	Immediate or future nursing actions that address the focus; appraisal of the care plan along with any changes required	Plan and implementation
R (Response)	Description of patient responses to any part of the medical or nursing care	Evaluation

The PIE Method

The PIE method, or more specifically, "APIE" (assessment, problem, intervention, evaluation), is a systematic approach of documenting to nursing process and nursing diagnosis. A problem-oriented system, **PIE charting** uses accompanying flow sheets that are individualized by each institution. Criteria for documentation are organized in the following manner:

A = Assessment: A complete patient assessment is conducted at the beginning of each shift. Results are documented under this section in the progress notes. Some institutions elect instead to use a daily patient assessment sheet designed to meet specific needs of the unit. Explanation of any deviation from the norm is included in the progress notes.

P = Problem: A problem list, or list of nursing diagnoses, is an important part of the APIE method of charting. The name or number of the problem being addressed is documented in this section.

I = Intervention: Nursing actions are performed, directed at resolution of the problem.

E = Evaluation: Outcomes of the implemented interventions are documented, including an evaluation of patient responses to determine the effectiveness of nursing interventions and the presence or absence of progress toward resolution of a problem.

Table 8–5 shows how APIE charting corresponds to the steps of the nursing process. Following is an example of a three-column documentation in the APIE format.

Example

DATE/TIME	PROBLEM	PROGRESS NOTES
9-12-2020 1000	Social isolation	**A:** States he does not want to sit with or talk to others; they "frighten" him; stays in room alone unless strongly encouraged to come out; no group involvement; at times listens to group conversations from a distance but does not interact; some hypervigilance and scanning noted **P:** Social isolation related to inability to trust, panic level of anxiety, and delusional thinking **I:** Initiated trusting relationship by spending time alone with patient; discussed his feelings regarding interactions with others; accompanied patient to group activities; provided positive feedback for voluntarily participating in assertiveness training **E:** Cooperative with therapy; still uncomfortable in the presence of a group of people; accepted positive feedback from nurse

TABLE 8–5 Validation of the Nursing Process With APIE Method

APIE CHARTING	WHAT IS RECORDED	NURSING PROCESS
A (Assessment)	Subjective and objective data about the patient that are gathered at the beginning of each shift	Assessment
P (Problem)	Name (or number) of nursing diagnosis being addressed from written problem list, and identified outcome for that problem (*Note*: If outcome appears on written care plan, it does not need to be repeated in daily documentation unless a change occurs.)	Diagnosis and outcome identification
I (Intervention)	Nursing actions performed, directed at problem resolution	Plan and implementation
E (Evaluation)	Appraisal of patient responses to determine effectiveness of nursing interventions	Evaluation

Electronic Documentation

Most health-care facilities have implemented an electronic health record (EHR) or electronic documentation system. Federal regulations and programs have incentivized the move to EHR systems by requiring health-care organizations to use them in order to receive Medicare and Medicaid reimbursement; as of 2015, progressive reductions in reimbursement have been initiated for health-care providers who are not demonstrating meaningful use of EHRs.

The rationale for this move is that EHR systems have been shown to improve both the quality of patient care and the efficiency of the health-care system (U.S. Government Accountability Office, 2010). Quality improvement and informatics are both QSEN competencies.

In 2003, the U.S. Department of Health and Human Services commissioned the Institute of Medicine (IOM) to study the capabilities of an EHR system. The IOM identified a set of eight core functions that EHR systems should perform in the delivery of safer, higher-quality, and more efficient health care (IOM, 2003):

1. **Health information and data:** EHRs provide more rapid access to important patient information (e.g., allergies, laboratory test results, a medication list, demographic information, and clinical narratives), thereby improving care providers' abilities to make sound clinical decisions in a timely manner.
2. **Results management:** Computerized results of all types (e.g., laboratory test results, radiology procedure result reports) can be accessed more easily by the provider at the time and place they are needed.
3. **3. Order entry and order management:** Computer-based order entries improve workflow processes by eliminating lost orders and ambiguities caused by illegible handwriting, generating related orders automatically, monitoring for duplicate orders, and improving the speed with which orders are executed.
4. **Decision support:** Computerized decision support systems enhance clinical performance for many aspects of health care. Reminders and prompts help improve adherence to regular screenings and other preventive practices. Other aspects of health-care support include identifying possible drug interactions and facilitating diagnosis and treatment.
5. **Electronic communication and connectivity:** Improved communication among care associates, such as medicine, nursing, laboratory, pharmacy, and radiology team members, can enhance patient safety and quality of care. Efficient communication among providers improves continuity of care, allows for more timely interventions, and reduces the risk of adverse events.
6. **Patient support:** Computer-based interactive patient education, self-testing, and self-monitoring have been shown to improve control of chronic illnesses.
7. **Administrative processes:** Electronic scheduling systems (e.g., for hospital admissions and outpatient procedures) increase the efficiency of healthcare organizations and provide more timely service to patients.
8. **Reporting and population health management:** Health-care organizations are required to report health-care data to government and private sectors for patient safety and public health. Uniform electronic data standards facilitate this process at the provider level, reduce the associated costs, and increase the speed and accuracy of the data reported.

Table 8–6 lists some of the advantages and disadvantages of paper records and EHRs.

TABLE 8–6 Advantages and Disadvantages of Paper Records and EHR Systems

PAPER*	EHR SYSTEM
ADVANTAGES	**ADVANTAGES**
■ People know how to use it.	■ Can be accessed by multiple providers from remote sites.
■ It is fast for current practice.	■ Facilitates communication between disciplines.
■ It is portable.	■ Provides reminders about completing information.
■ It is nonbreakable.	■ Provides warnings about incompatibilities of medications or variances from normal standards.
■ It accepts multiple data types, such as graphs, photographs, drawings, and text.	■ Reduces redundancy of information.
■ Legal issues and costs are understood.	■ Requires less storage space and is more difficult to lose.
DISADVANTAGES	■ Easier to research for audits, quality assurance, and epidemiological surveillance.
■ It can be lost.	■ Provides immediate retrieval of information (e.g., test results).
■ It is often illegible and incomplete.	■ Provides links to multiple databases of health-care knowledge, thus providing diagnostic support.
■ It has no remote access.	■ Decreases charting time.
■ It can be accessed by only one person at a time.	■ Reduces errors due to illegible handwriting.
■ It is often disorganized.	■ Facilitates billing and claims procedures.
■ Information is duplicated.	**DISADVANTAGES**
■ It is hard to store.	■ Excessive expense to initiate the system.
■ It is difficult to research, and continuous quality improvement is laborious.	■ Substantial learning curve involved for new users; training and retraining required.
■ Same client has separate records at each facility (physician's office, hospital, home care).	■ Stringent requirements to maintain security and confidentiality.
■ Records are shared only through hard copy.	■ Technical difficulties are possible.
	■ Legal and ethical issues involving privacy and access to client information.
	■ Requires consistent use of standardized terminology to support information sharing across wide networks.

*From Young, K.M., & Catalano, J.T. (2015). Nursing informatics. In J.T. Catalano (Ed.), *Nursing now! Today's issues, tomorrow's trends* (7th ed.). Philadelphia: F.A. Davis. With permission.

Summary and Key Points

- The nursing process provides a methodology by which nurses may deliver care using a systematic, scientific approach.
- The focus of the nursing process is goal directed and based on a decision-making or problem-solving model consisting of six steps: assessment, diagnosis, outcome identification, planning, implementation, and evaluation.

- Assessment is a systematic, dynamic process by which the nurse, through interaction with the patient, significant others, and health-care providers, collects and analyzes data about the patient.
- Nursing diagnoses are clinical judgments about individual, family, or community responses to actual or potential health problems and life processes.
- Outcomes are measurable, expected, patient-focused goals that translate into observable behaviors.
- Evaluation is the process of determining both the patient's progress toward the attainment of expected outcomes and the effectiveness of nursing care.
- The psychiatric nurse uses the nursing process to assist patients to adapt successfully to stressors within the environment.
- The nurse serves as a valuable member of the interdisciplinary treatment team, working both independently and cooperatively with other team members.
- Case management is an innovative model of care delivery that serves to provide quality patient care while controlling health-care costs. Critical pathways of care serve as the tools for provision of care in a case management system.
- Nurses may serve as case managers, who are responsible for negotiating with multiple health-care providers to obtain a variety of services for the patient.
- Concept mapping is a diagrammatic teaching and learning strategy that allows students and faculty to visualize interrelationships between medical diagnoses, nursing diagnoses, assessment data, and treatments. The concept map care plan is an innovative approach to planning and organizing nursing care.
- Nurses must document that the nursing process has been used in the delivery of care. Three methods of documentation that reflect use of the nursing process are POR, Focus Charting, and the PIE method.
- Many health-care facilities have implemented the use of EHRs or electronic documentation systems. EHRs have been shown to improve both the quality of patient care and the efficiency of the health-care system.

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Review Questions

1. The nurse is using nursing process to care for a client who is suicidal. Which of the following nursing actions is a part of the assessment step of the nursing process?
a. Identifies nursing diagnosis: Risk for suicide.
b. Notes that client's family reports recent suicide attempt.
c. Prioritizes the necessity of maintaining a safe client environment.
d. Obtains a commitment from the patient to work collaboratively to identify adaptive coping skills.

2. The nurse is using nursing process to care for a client who is suicidal. Which of the following nursing actions is a part of the diagnosis step of the nursing process?
a. Identifies the client as "At risk for suicide."

b. Notes that client's family reports recent suicide attempt.
c. Prioritizes the necessity for maintaining a safe environment for the client.
d. Obtains a commitment from the patient to work collaboratively to identify adaptive coping skills.

3. The nurse is using nursing process to care for a client who is suicidal. Which of the following nursing actions is a part of the outcome identification step of the nursing process?
a. Prioritizes the necessity for maintaining a safe environment for the client.
b. Determines whether nursing interventions have been appropriate to achieve desired results.
c. Obtains a commitment from the patient to work collaboratively to identify adaptive coping skills.
d. Identifies that the "Client will not harm self during hospitalization."

4. The nurse is using nursing process to care for a client who is suicidal. Which of the following nursing actions is a part of the planning step of the nursing process?
a. Prioritizes the necessity for maintaining a safe environment for the client.
b. Determines whether nursing interventions have been appropriate to achieve desired results.
c. Obtains a commitment from the patient to work collaboratively to identify adaptive coping skill.
d. Identifies that the "Client will not harm self during hospitalization."

5. The nurse is using nursing process to care for a client who is suicidal. Which of the following nursing actions is a part of the implementation step of the nursing process?
a. Prioritizes the necessity for maintaining a safe environment for the client.
b. Determines whether nursing interventions have been appropriate to achieve desired results.
c. Collaborates with the client to develop a plan for ongoing safety and suicide prevention.
d. Identifies that the "Client will not harm self during hospitalization."

6. The nurse is using nursing process to care for a client who is suicidal. Which of the following nursing actions is a part of the evaluation step of the nursing process?
a. Prioritizes the necessity for maintaining a safe environment for the client.
b. Determines whether nursing interventions have been appropriate to achieve desired goals.
c. Collaborates with the client to develop a plan for ongoing safety and suicide prevention.
d. Identifies that the "Client will not harm self during hospitalization."

Clinical Judgment Questions

7. A 15-year-old female client is admitted to the adolescent psychiatric unit with a diagnosis of anorexia nervosa. She is 5 feet 5 inches tall and weighs 82 pounds.

She was selected to join the cheerleading squad for the fall but states that she is not as good as the others on the squad. The treatment team has identified the following problems: refusal to eat, occasional purging, refusing to interact with staff and peers, and fear of failure. Which of the following nursing diagnoses would be appropriate for this client? (Select all that apply.)

a. Social isolation
b. Disturbed body image
c. Low self-esteem
d. Imbalanced nutrition: Less than body requirements

8. Which of the following nursing diagnoses would be the **priority** diagnosis for the client described in question 7?

a. Social isolation
b. Disturbed body image
c. Low self-esteem
d. Imbalanced nutrition: Less than body requirements

9. The nurse is transferring a client to a different unit and is providing a transfer report to the nurse that will be receiving this client. The receiving nurse asks what medications this client received within the last 2 hours. Which source should the nurse use to convey this information?

a. Handwritten notes from a shift change report.
b. Memory of what was given to the client earlier.
c. The electronic health record.
d. All of the above.

10. A client is admitted to the psychiatric unit with depression. Which of these activities by the nurse is a priority?

a. Assess the client's risk for suicide.
b. Establish a care plan that includes suicide precautions.
c. Contact the physician for orders.
d. Orient the client to unit activities.

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*Disturbed sensory perception and disturbed thought processes have been removed from the NANDA-I list of approved nursing diagnoses (NANDA-I, 2012). However, they will continue to be used in this textbook because of their appropriateness to certain behaviors.

*Content in this section is adapted from Doenges, Moorhouse, and Murr (2019) and Schuster (2016).

9 Therapeutic Groups

CORE CONCEPTS

Group

Group Therapy

CHAPTER OUTLINE

Objectives
Homework Assignment
Functions of a Group
Types of Groups
Physical Conditions That Influence Group Dynamics
Therapeutic Factors
Phases of Group Development
Leadership Styles
Member Roles
Psychodrama
The Role of the Nurse in Therapeutic Groups
Summary and Key Points
Review Questions
Clinical Judgment Questions

KEY TERMS

altruism
autocratic
catharsis
democratic
laissez-faire
psychodrama
universality

OBJECTIVES

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

1. Define a group.
2. Discuss eight functions of a group.
3. Identify various types of groups.
4. Describe physical conditions that influence groups.
5. Discuss therapeutic factors that occur in groups.
6. Describe the phases of group development.
7. Identify various leadership styles in groups.
8. Identify various roles that members assume within a group.
9. Discuss psychodrama as a specialized form of group therapy.
10. Describe the role of the nurse in group therapy.

HOMEWORK ASSIGNMENT

Please read the chapter and answer the following questions:

1. What is the difference between therapeutic groups and group therapy?
2. What are the expectations of the leader in the initial or orientation phase of group development?
3. How does an autocratic leadership style affect member enthusiasm and morale?
4. How does the size of the group influence group dynamics?

Human beings are complex creatures who share their activities of daily living with various *groups* of people. “From friendships to families to entire societies, humans naturally form social groups; in fact, this tendency is essential to what it means to be human” (Bradley, 2018). Groups provide a sense of belonging, establish norms for accepted behavior, provide support, and facilitate problem-solving.

Health-care professionals share their personal lives with groups of people and encounter multiple group situations in their professional operations. Team conferences, committee meetings, grand rounds, and in-service sessions are but a few instances in which this occurs. In psychiatry, work with clients and families often takes the form of groups. With group work, not only does the nurse have the opportunity to reach out to a greater number of people at one time, but those individuals also assist each other by sharing their feelings, opinions, ideas, and behaviors with the group. Clients learn from each other in a group setting.

This chapter explores various types and methods of therapeutic groups that can be used with psychiatric clients and the role of the nurse in group intervention.

CORE CONCEPT

Group

A *group* is a collection of individuals whose association is founded on commonalities of interest, values, norms, or purpose. Membership in a group is generally by chance (born into the group), by choice (voluntary affiliation), or by circumstance (the result of life-cycle events over which an individual may or may not have control).

Functions of a Group

Sampson and Marthas (1990) outlined the following eight functions that groups serve for their members. They contend that groups may serve more than one function and usually serve different functions for different members of the group.

1. **Socialization:** The cultural group into which individuals are born begins the process of teaching social norms. This process is continued throughout their lives by members of other groups with which they become affiliated.
2. **Support:** One's fellow group members are available in times of need. Individuals derive a feeling of security from group involvement.
3. **Task completion:** Group members provide assistance in endeavors that are beyond the capacity of one individual alone or when results can be achieved more effectively as a team.
4. **Camaraderie:** Members of a group provide the joy and pleasure that individuals seek from interactions with significant others.
5. **Information sharing:** Learning takes place within groups. Knowledge is gained when individual members learn how others in the group have resolved situations similar to those with which they are currently experiencing.
6. **Normative influence:** This function relates to the ways in which groups enforce the established norms. As group members

interact, they influence each other about expected norms for communication and behavior.

7. **Empowerment:** Groups help to bring about improvement in existing conditions by providing support to individual members who seek to bring about change. Groups have power that individuals alone do not.
8. **Governance:** Groups that provide oversight functions and direction of activities (such as strategic planning or quality assurance) often within the context of a larger group organization.

Types of Groups

The functions of a group vary depending on the reason the group was formed. Clark (2009) identified three types of groups in which nurses most often participate: task, teaching, and supportive/therapeutic groups.

Task Groups

The function of a task group is to accomplish a specific outcome or task. The focus is on solving problems and making decisions to achieve this outcome. Often, a deadline is placed on completion of the task. Because a satisfactory outcome is so important to these types of groups, conflicts may be smoothed over or ignored to focus on the priority at hand.

Teaching Groups

Teaching, or educational, groups convey knowledge and information to a number of individuals. Nurses can be involved in many types of teaching groups, such as medication education, childbirth education, breast self-examination, and effective parenting classes. These groups usually have a set time frame or a specific number of meetings. Members learn from each other as well as from the designated instructor. The objective of teaching groups is for the learner to verbalize or demonstrate mastery of the material presented by the end of the designated period.

Supportive/Therapeutic Groups

Supportive or therapeutic groups are primarily concerned with preventing future upsets by teaching participants effective ways to deal with emotional stress arising from situational or developmental crises.

CORE CONCEPT

Group Therapy

A form of psychosocial treatment in which several clients meet together with a therapist for purposes of sharing, gaining personal insight, and improving interpersonal coping strategies.

For the purposes of this text, it is important to differentiate between *therapeutic groups* and *group therapy.* Leaders of group therapy generally have advanced degrees in psychology, social work, nursing, or medicine. They often have additional training or experience in conducting group psychotherapy based on various theoretical frameworks such as psychoanalytic, psychodynamic, interpersonal, or family dynamics, and are supervised by accomplished professionals. Group therapy leaders use these theoretical approaches to encourage improvement in group members' abilities to function on an interpersonal level.

Therapeutic groups, on the other hand, are not designed for psychotherapy. They focus instead on group relations, interactions among group members, and the consideration of selected issues. Like group therapists, individuals who lead therapeutic groups must be knowledgeable in *group process;* that is, the *way* in which group members interact with each other. Interruptions, silences, judgments, glares, and scapegoating are examples of group processes. These interactions may occur whether or not there is a designated group leader, but nurses acting as group leaders can guide the ways in which members interact to facilitate accomplishing the group's goals or tasks. This guidance is one reason why group leaders are often referred to as *group facilitators.* They must also have a thorough knowledge of *group content,* the topic or issue being discussed by

the group, and the ability to present the topic in language that can be understood by all members. Many nurses who work in psychiatry lead supportive/therapeutic groups.

Self-Help Groups

Nurses may also be involved in self-help groups, a type of group that has grown in number and credibility in recent years. Self-help groups allow clients to talk about their fears and relieve feelings of isolation while receiving comfort and advice from others undergoing similar experiences. Examples of self-help groups are those for clients and families dealing with disorders such as Alzheimer's disease or anorexia nervosa, Weight Watchers, Alcoholics Anonymous, Reach to Recovery, Parents Without Partners, Overeaters Anonymous, Adult Children of Alcoholics, and many others related to specific needs or illnesses. These groups may or may not have a professional leader or consultant. They are run by the members, and leadership often rotates from member to member.

Nurses may become involved with self-help groups either voluntarily or because members have their advice or participation. The nurse may function as a referral agent, resource person, member of an advisory board, or leader of the group. Self-help groups are a valuable source of referral for clients with specific problems. However, nurses must be knowledgeable about the purposes of the group, membership, leadership, benefits, and problems that might threaten the success of the group before making referrals to their patients for a specific self-help group. The nurse may find it necessary to attend several meetings of a particular group, if possible, to assess its effectiveness of purpose and appropriateness for patient referral.

Physical Conditions That Influence Group Dynamics

The physical aspects, including arrangement of seating, the number of group members, and whether the membership is consistent or

variable, has an impact on the dynamics of interaction within the group.

Seating

When preparing the setting for a group, there should be no barrier between members. For example, a circle of chairs is better than chairs set around a table. Members should be encouraged to sit in different chairs at each meeting. This openness and change create a feeling of discomfort that encourages anxious and unsettled behaviors that can then be explored within the group.

Size

Various authors have suggested different ranges of size as ideal for group interaction: 5 to 10 (Yalom & Leszcz, 2005), 2 to 15 (Sampson & Marthas, 1990), and 4 to 12 (Clark, 2009). Group size does make a difference in the interaction among members. The larger the group, the less time is available to devote to individual members. In larger groups, more aggressive individuals are most likely to be heard, whereas quieter members may be left out of the discussions altogether. Understanding this dynamic alerts the nurse group leader to this possibility and allows him or her to facilitate interaction that promotes greater involvement for all members. However, larger groups provide more opportunities for individuals to learn from other members. The wider range of life experiences and knowledge provides a greater potential for effective group problem-solving. Classic research (Hackman & Vidmar, 1970) indicates that a composition of no more than 7 members provides the most favorable climate for optimal group interaction and relationship development.

Membership

Whether the group is open or closed is another condition that influences the dynamics of group process. Open groups are those in which members leave and others join at any time while the group is active. The continuous movement of members in and out of the group creates the type of discomfort described previously that encourages unsettled behaviors in individual members and fosters

the exploration of feelings. These are the most common types of groups held on short-term inpatient units, although they are used in outpatient and long-term care facilities as well. Closed groups usually have a predetermined, fixed time frame. All members join at the time the group is organized and terminate at the end of the designated time period. Closed groups are often composed of individuals with common issues or problems they wish to address.

Therapeutic Factors

Why are therapeutic groups helpful? Yalom and Leszcz (2005) described 11 therapeutic factors that individuals can achieve through interpersonal interactions within the group, some of which are present in most groups in varying degrees:

1. **Instillation of hope:** By observing the progress of others in the group with similar problems, a group member garners hope that his or her problems can also be resolved.
2. **Universality:** Through **universality,** individuals come to realize that they are not alone in the problems, thoughts, and feelings they are experiencing. Anxiety is relieved by the support and understanding of others in the group who share similar (universal) experiences.
3. **Imparting of information:** Knowledge is gained through formal instruction as well as sharing of advice and suggestions among group members.
4. **Altruism: Altruism** is assimilated by group members through mutual sharing and concern for each other. Providing assistance and support to others creates a positive self-image and promotes self-growth.
5. **Corrective recapitulation of the primary family group:** Group members are able to reexperience early family conflicts that remain unresolved. Attempts at resolution are promoted through feedback and exploration.
6. **Development of socializing techniques:** Through interaction with and feedback from other members within the group,

individuals are able to correct maladaptive social behaviors and learn and develop new social skills.

7. **Imitative behavior:** In a group setting, one who has mastered a particular psychosocial skill or developmental task can be a valuable role model for others. Individuals may imitate selected behaviors that they wish to develop in themselves.
8. **Interpersonal learning:** The group offers many and varied opportunities for interacting with other people. Insight is gained regarding how one perceives and is being perceived by others.
9. **Group cohesiveness:** Members develop a sense of belonging that separates the individual ("I am") from the group ("we are"). Out of this alliance emerges a common feeling that both individual members and the total group are of value to each other.
10. **Catharsis:** Within the group, members are able to express both positive and negative feelings—perhaps feelings that have never been expressed before—in a nonthreatening atmosphere. This **catharsis,** or open expression of feelings, is beneficial for the individual within the group.
11. **Existential factors:** The group is able to help individual members take direction of their own lives and accept responsibility for the quality of their existence.

It may be helpful for a group leader to explain these therapeutic factors to members. Positive responses are experienced by individuals who understand and can recognize therapeutic factors as they occur within the group.

Phases of Group Development

Groups, like individuals, move through phases of life-cycle development. Ideally, groups progress from the phase of infancy to advanced maturity to fulfill the objectives set forth by the membership. As with individuals, some groups become fixed in early developmental levels and never progress, or they experience periods of regression in the developmental process. Three phases of group development are discussed here.

Phase I. Initial or Orientation Phase

Group Activities

Leader and members work together to establish the rules that will govern the group (e.g., when and where meetings will occur, the importance of confidentiality, how meetings will be structured). Goals of the group are established. Members are introduced to each other.

Leader Expectations

The leader is expected to orient members to specific group processes, encourage members to participate without disclosing too much too soon, promote an environment of trust, and ensure that rules established by the group do not interfere with fulfillment of the goals.

Member Behaviors

In phase I, members have not yet established trust and will respond to this lack of trust by being overly polite. There is a fear of not being accepted by the group. They may try to “get on the good side” of the leader with compliments and conforming behaviors. A power struggle may ensue as members compete for their position in the “pecking order” of the group.

Phase II. Middle or Working Phase

Group Activities

Ideally, during the working phase, cohesiveness has been established within the group. This phase is when productive work toward completion of the task is undertaken. Problem-solving and decision-making occur within the group. In the mature group, cooperation prevails, and differences and disagreements are confronted and resolved.

Leader Expectations

The leader becomes less of a leader and more of a facilitator during the working phase. Some leadership functions are shared by certain members of the group as they progress toward resolution. The

leader helps to resolve conflict and continues to foster cohesiveness among the members while ensuring that they do not deviate from the intended task or purpose for which the group was organized.

Member Behaviors

At this point, trust has been established among the members. They turn more often to each other and less often to the leader for guidance. They accept criticism from each other, using it constructively to create change. Occasionally, subgroups form in which two or more members conspire with each other to the exclusion of the rest of the group. These subgroups must be confronted and discussed by the entire membership to maintain group cohesion. Conflict is managed by the group with minimal assistance from the leader.

Phase III. Final or Termination Phase

Group Activities

The longer a group has existed, the more difficult termination is likely to be for the members. Termination should be mentioned from the outset of group formation and be discussed in depth for several meetings before the final session. A sense of loss that precipitates the grief process may be evident, particularly in groups that have been successful in their stated purpose.

Leader Expectations

In the termination phase, the leader encourages the group members to reminisce about what has occurred within the group, review the goals and discuss the actual outcomes, and provide feedback to each other about individual progress within the group. The leader encourages members to discuss feelings of loss associated with termination of the group.

Member Behaviors

Members may express surprise when the group actually ends. This expression represents the grief response of denial, which may then progress to anger. Anger toward other group members or the leader

may reflect feelings of abandonment (Sampson & Marthas, 1990). These feelings may lead to individual members' discussions of previous losses for which similar emotions were experienced. Successful termination of the group may help members develop the skills needed when losses occur in other dimensions of their lives.

Leadership Styles

Lippitt and White (1958) identified three of the most common group leadership styles: autocratic, democratic, and laissez-faire. Table 9–1 outlines various similarities and differences between the three leadership styles.

Autocratic

Autocratic leaders have personal goals for the group. They withhold information from group members, particularly issues that may interfere with the achievement of their own objectives. The message that is conveyed to the group is: "We will do it my way. My way is best." The focus in this style of leadership is on the leader. Members are dependent on the leader for problem-solving, decision-making, and permission to perform. The approach of the autocratic leader is one of persuasion, striving to convince others in the group that his or her ideas and methods are superior. Productivity is high with this type of leadership, but often morale within the group is low because of the lack of member input and creativity.

Democratic

The **democratic** leadership style focuses on the members of the group. Information is shared with members to allow them to make decisions regarding group goals. Members are encouraged to participate fully in solving problems that affect the group, including taking action to effect change. The message that is conveyed to the group is: "Decide what must be done, consider the alternatives, make a selection, and proceed with the actions required to complete the task." The leader provides guidance and expertise as needed. Productivity is lower than it is with autocratic leadership, but morale

is much higher because of the extent of input allowed all members of the group and the potential for individual creativity.

TABLE 9–1 **Leadership Styles—Similarities and Differences**			
CHARACTERISTICS	AUTOCRATIC	DEMOCRATIC	LAISSEZ-FAIRE
Focus	Leader	Members	Undetermined
Task strategy	Members are persuaded to adopt leader's ideas	Members engage in group problem-solving	No defined strategy exists
Member participation	Limited	Unlimited	Inconsistent
Individual creativity	Stifled	Encouraged	Not addressed
Member enthusiasm and morale	Low	High	Low
Group cohesiveness	Low	High	Low
Productivity	High	High (may not be as high as autocratic)	Low
Individual motivation and commitment	Low (tend to work only when leader is present to urge them to do so)	High (satisfaction derived from personal input and participation)	Low (feelings of frustration from lack of direction or guidance)

Laissez-Faire

This leadership style allows people to do as they please. There is no direction from the leader. In fact, the **laissez-faire** leader's approach is noninvolvement. Goals for the group are undefined. No decisions are made, no problems are solved, and no action is taken. Members become frustrated and confused, and productivity and morale are low.

Member Roles

Benne and Sheats (1948) identified three major types of roles that individuals play within the membership of the group. These are roles that serve to

1. Complete the task of the group.
2. Maintain or enhance group processes.
3. Fulfill personal or individual needs.

Task roles and maintenance roles contribute to the success or effectiveness of the group. Personal roles satisfy the needs of the individual members, sometimes to the extent of interfering with the effectiveness of the group. Table 9–2 outlines specific roles within these three major types and the behaviors associated with each.

Psychodrama

A specialized type of therapeutic group, called **psychodrama,** was introduced by Jacob L. Moreno, a Viennese psychiatrist. Moreno's method employs a dramatic approach in which clients become "actors" in life-situation scenarios.

TABLE 9–2 **Member Roles Within Groups**

ROLE	BEHAVIORS
TASK ROLES	
Coordinator	Clarifies ideas and suggestions that have been made within the group; fosters relationships between members to facilitate pursuit of common goals
Evaluator	Examines group plans and performance, measuring against group standards and goals
Elaborator	Explains and expands on group plans and ideas
Energizer	Encourages and motivates group to perform at its maximum potential
Initiator	Outlines the task at hand for the group and proposes methods for solution
Orienter	Maintains direction within the group
MAINTENANCE ROLES	
Compromiser	Relieves conflict within the group by assisting members to reach a compromise agreeable to all
Encourager	Offers recognition and acceptance of others' ideas and contributions
Follower	Listens attentively to group interaction; is a passive participant
Gatekeeper	Encourages acceptance of and participation by all members of the group
Harmonizer	Minimizes tension within the group by intervening when disagreements produce conflict
INDIVIDUAL (PERSONAL) ROLES	
Aggressor	Expresses negativism and hostility toward other members; may use sarcasm to degrade the status of others
Blocker	Resists group efforts; demonstrates rigid and sometimes irrational behaviors that impede group progress
Dominator	Manipulates others to gain control; behaves in an authoritarian manner
Help-seeker	Uses the group to gain sympathy from others; seeks to increase self-confidence from group feedback; lacks concern for others or the group as a whole
Monopolizer	Maintains control of the group by dominating the conversation
Mute or silent	Does not participate verbally; remains silent for a variety of

member	reasons—may feel uncomfortable with self-disclosure or may be seeking attention through silence
Recognition seeker	Talks about personal accomplishments to gain attention for self
Seducer	Shares intimate details about self with group; is the least reluctant of the group to do so; may frighten others in the group and inhibit group progress with excessive premature self-disclosure

Sources: Benne, K.D., & Sheats, P. (1948, Spring). Functional roles of group members. *Journal of Social Issues, 4*(2), 41-49; Hobbs, D.J., & Powers, R.C. (1981). *Group member roles: For group effectiveness.* Ames: Iowa State University, Cooperative Extension Service; Larson, M.L., & Williams, R.A. (1978). How to become a better group leader? Learn to recognize the strange things that happen to some people in groups. *Nursing, 8*(8), 65-72.

The group leader is called the *director,* group members are the *audience,* and the *set* or *stage* may be specially designed or just a room or area selected for this purpose. Actors are members from the audience who agree to take part in the “drama” by role-playing a situation about which the director has informed them. Usually, the situation is an issue with which an individual client has been struggling. The client plays the role of himself or herself and is called the *protagonist.* In this role, he or she is able to express true feelings toward individuals (represented by group members) with whom unresolved conflicts exist.

In some instances, the group leader may ask for a client to volunteer as the protagonist for that session. The client may choose a situation he or she wishes to enact and select the audience members to portray the roles of others in the life situation. The psychodrama setting provides the client with a safer and less threatening atmosphere than the real situation, facilitating the expression of true feelings and resolution of interpersonal conflicts.

When the drama has been completed, group members from the audience discuss the situation they have observed, offer feedback, express their feelings, and relate their own similar experiences. In this way, all group members benefit from the session, either directly or indirectly.

Nurses often serve as actors or role players in psychodrama sessions. Leaders of psychodrama have graduate degrees in psychology, social work, nursing, or medicine with additional training in group therapy and specialty preparation to become a psychodramatist.

The Role of the Nurse in Therapeutic Groups

Nurses participate in group situations on a daily basis. In health-care settings, nurses serve on or lead task groups that create policy, describe procedures, and plan patient care. They are also involved in a variety of other groups aimed at the institutional effort of serving the consumer. Nurses are encouraged to use the steps of the nursing process as a framework for task group leadership.

In psychiatry, nurses may lead various types of therapeutic groups, such as patient education, assertiveness training, grief support, parenting, and transition to discharge groups, among others. To function effectively in the leadership capacity for these groups, nurses must recognize the various processes that occur in groups, such as the phases of group development, the roles that people play within groups, and the motivation behind these behaviors. They also need to be able to select the most appropriate leadership style for the type of group. Generalist nurses may develop these skills as part of their undergraduate educations, or they may pursue additional study while serving and learning as the coleader of a group with a more experienced nurse leader.

Generalist nurses in psychiatry should not serve as leaders of psychotherapy groups. The *Psychiatric-Mental Health Nursing Scope and Standards of Practice* (American Nurses Association, American Psychiatric Nurses Association, & International Society of Psychiatric Nurses, 2014) specifies that nurses who serve as group psychotherapists should have a minimum of a master's degree in psychiatric nursing. Educational preparation in group theory, extended practice as a group coleader or leader under the supervision of an experienced psychotherapist, and participation in

group therapy on an experiential level are also recommended. Additional specialist training is required beyond the master's level to prepare nurses to become family therapists or psychodramatists.

Leading therapeutic groups is within the realm of nursing practice. Because group work is such a common therapeutic approach in the discipline of psychiatry, nurses working in this field must continually strive to expand their knowledge and use of group process as a significant psychiatric nursing intervention.

CLINICAL PEARL Knowledge of human behavior in general and the group process in particular is essential to effective group leadership.

Summary and Key Points

- A group has been defined as a collection of individuals whose association is founded on shared commonalities of interest, values, norms, or purpose.
- Eight group functions have been identified: socialization, support, task completion, camaraderie, informational, normative, empowerment, and governance.
- The three major types of group are task groups, teaching groups, and supportive/therapeutic groups.
- The function of task groups is to solve problems, make decisions, and achieve a specific outcome.
- In teaching groups, knowledge and information are conveyed to several individuals.
- The function of supportive/therapeutic groups is to educate people to deal effectively with emotional stress in their lives.
- In self-help groups, members share the same type of problem and help each other to prevent decompensation related to that problem.
- Therapeutic groups differ from group therapy in that the focus is not on psychotherapy but rather on interaction and relationships among group members about a selected issue. Group therapy is

more focused on specific models of psychotherapy, and the leaders generally have advanced degrees in psychology, social work, nursing, or medicine. Placement of the seating and size of the group can influence group interaction.

- Groups can be open (when members leave and others join at any time while the group is active) or closed (when groups have a predetermined, fixed time frame and all members join at the same time and leave when the group disbands).
- Yalom and Leszcz (2005) describe the following therapeutic factors that individuals derive from participation in therapeutic groups: instillation of hope, universality, imparting of information, altruism, corrective recapitulation of the primary family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, and existential factors.
- Groups progress through three phases: the initial (orientation) phase, the working phase, and the termination phase.
- Group leadership styles include autocratic, democratic, and laissez-faire.
- Members play various roles within groups. These roles are categorized as task, maintenance, and personal roles.
- Psychodrama is a specialized type of group therapy that uses a dramatic approach in which clients become “actors” in life-situation scenarios.
- The psychodrama setting provides the client with a safer and less-threatening atmosphere than the real situation in which to express and work through unresolved conflicts.
- Nurses lead various types of therapeutic groups in the psychiatric setting. Knowledge of human behavior in general and the group process in particular is essential to effective group leadership.
- Specialized training, in addition to a master’s degree, is required for nurses to serve as group psychotherapists or psychodramatists.

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Review Questions

1. A nurse who is leading a childbirth preparation group shows a film each week and sets out reading materials. She expects the participants to utilize their time on a topic of their choice or practice skills they have observed in the films. Which type of group and style of leadership is described in this situation?
   a. Task group, democratic leadership
   b. Teaching group, laissez-faire leadership
   c. Self-help group, democratic leadership
   d. Supportive-therapeutic group, autocratic leadership

2. A psychiatric nurse is leading a group for women who desire to lose weight. The criterion for membership is that members must be at least 20 pounds overweight. All have tried to lose weight on their own many times in the past without success. At their first meeting, the nurse provides suggestions as the members determine what their goals will be and how they plan to go about achieving those goals. They decide how often they want to meet and what they plan to do at each meeting. Which type of group and style of leadership is described in this situation?
   a. Task group, autocratic leadership
   b. Teaching group, democratic leadership
   c. Self-help group, laissez-faire leadership
   d. Supportive-therapeutic group, democratic leadership

3. A staff nurse on a surgical unit is the leader of a newly established group of staff nurses organized to determine ways to decrease the number of medication errors occurring on the unit. At each meeting, he addresses the group to convince the members to adopt his ideas. Which type of group and style of leadership is described in this situation?
   a. Task group, autocratic leadership

b. Teaching group, autocratic leadership
c. Self-help group, democratic leadership
d. Supportive-therapeutic group, laissez-faire leadership

4. A nurse leader is explaining about group "therapeutic factors" to members of the group. She tells the group that group situations are beneficial because members can see that they are not alone in their experiences. Which of the following therapeutic factors is the nurse describing?
a. Altruism
b. Imitative behavior
c. Universality
d. Imparting of information

5. In a bereavement group for widows, one of the new members hears a longer-term member describe that the group support has helped her adjust to the loss of her husband. The new member states, "Well, maybe I can get through this, too." This statement is evidence of which of the following therapeutic factors?
a. Universality
b. Imitative behavior
c. Installation of hope
d. Imparting of information

Clinical Judgment Questions

6. A nurse has been asked to facilitate a group in the outpatient mental health clinic that is focused on helping patients problem-solve issues with adherence to medications. Which of these decisions about group size is most appropriate?
a. The group should be open to all patients who express interest.
b. The optimal size for this type of group is around 7 to 8 patients.
c. Patients should democratically decide on the size of the group.
d. The group should be limited to the first 35 patients who sign up.

7. A psychiatric nurse has been asked to lead an educational group on anger management for patients admitted to the psychiatric

unit. Which of these actions by the nurse is the most important priority?

a. Provide information and handouts on anger management.
b. Ask patients how long they would like the group to last.
c. Restrict the group to only those who have been complying with unit rules and expectations.
d. Ask the patients if they would rather have a group on something else.

8. A generalist nurse in the outpatient mental health clinic is approached by the medical director who requests that the nurse initiate a cognitive behavior therapy group. Which of these is the most appropriate action by the nurse?

a. Establish a self-help group for any patients who are interested.
b. Conduct cognitive behavior therapy for a small group of 7 to 10 patients.
c. Educate the medical director that according to nursing practice standards, therapy groups should be conducted by nurses who have a minimum of a master's degree in psychiatric nursing.
d. Ask the nursing supervisor for approval to initiate the medical director's request.

9. The nursing supervisor asks one of the staff nurses to initiate a group with other staff nurses to identify new ways to prevent patient falls. Which of these would be the most appropriate style of leadership for the nurse to implement?

a. Autocratic
b. Democratic
c. Laissez-faire
d. Militaristic

10. A nurse is conducting a diabetic medication education group for patients on a medical unit. Which of these actions by the nurse is the most important priority during the first meeting of this group?

a. Ask the patients where they would like to begin.
b. Try to identify what role each of the members is assuming.
c. Conduct fingerstick blood sugars on each attendee.

d. Explain how the meetings will be structured.

IMPLICATIONS OF RESEARCH FOR EVIDENCE-BASED PRACTICE

Atieno-Okech, J.E., Pimpleton, A.M., Vannatta, R., & Champe, J. (2015). Intercultural communication: An application to group work. *Journal for Specialists in Group Work, 40*(3), 268-293. doi.org/10.1080/01933922.2015.1056568

DESCRIPTION OF THE STUDY: Interdisciplinary literature on intercultural communication was reviewed to serve as a source of evidence-based strategies for improving intercultural communication. The authors note that as the diversity of the U.S. population continues to grow, counseling and therapy groups will grow in diversity and demand attention to intercultural communication to remain an effective tool for support, psychoeducation, and therapy.

RESULTS OF THE STUDY: The literature supports that discrepancies in communication style, differing cultural values, and ethnocentrism have been identified as major intercultural barriers in communication. “Languaculture,” a concept developed by Agar (1994), refers to culturally specific ways of interpreting language and is identified as an important knowledge base for group leaders. The case study presented by the authors describes a white female group leader who was using the communication technique of reflection with an African American male who perceived this reflection of his feelings as a taunt rather than as helpful. Attempting to “curiously and respectfully” seek understanding when these miscommunications occur is identified as a group leader’s responsibility.

Other studies found that contact alone did not translate into improved communication and relationships in an intercultural group. The biggest deterrents were apathy, ethnocentrism, and inexperience. Therefore the group leader must be aware of and attend to cues that may indicate a breakdown in communication between members before conflict or outright hostility arises. Studies showed that emotional intelligence is associated with the ability to read verbal and nonverbal cues, so this is an important skill for group leaders.

IMPLICATIONS FOR NURSING PRACTICE: Nurses will likely be engaged in intercultural groups among peers in the workplace as well as when leading therapeutic patient groups. The following skills are identified as important to evidence-based practice when leading groups:

1. Awareness of one’s own cultural values and biases to evaluate and counter ethnocentrism as a barrier to communication
2. Training in culturally specific ways of interpreting language and communication

3. Emotional intelligence skills to recognize when communication breakdowns are surfacing
4. An attitude of wanting to understand and correct intercultural miscommunication when it occurs

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