Manual of Psychiatric
Clinical
Competencies

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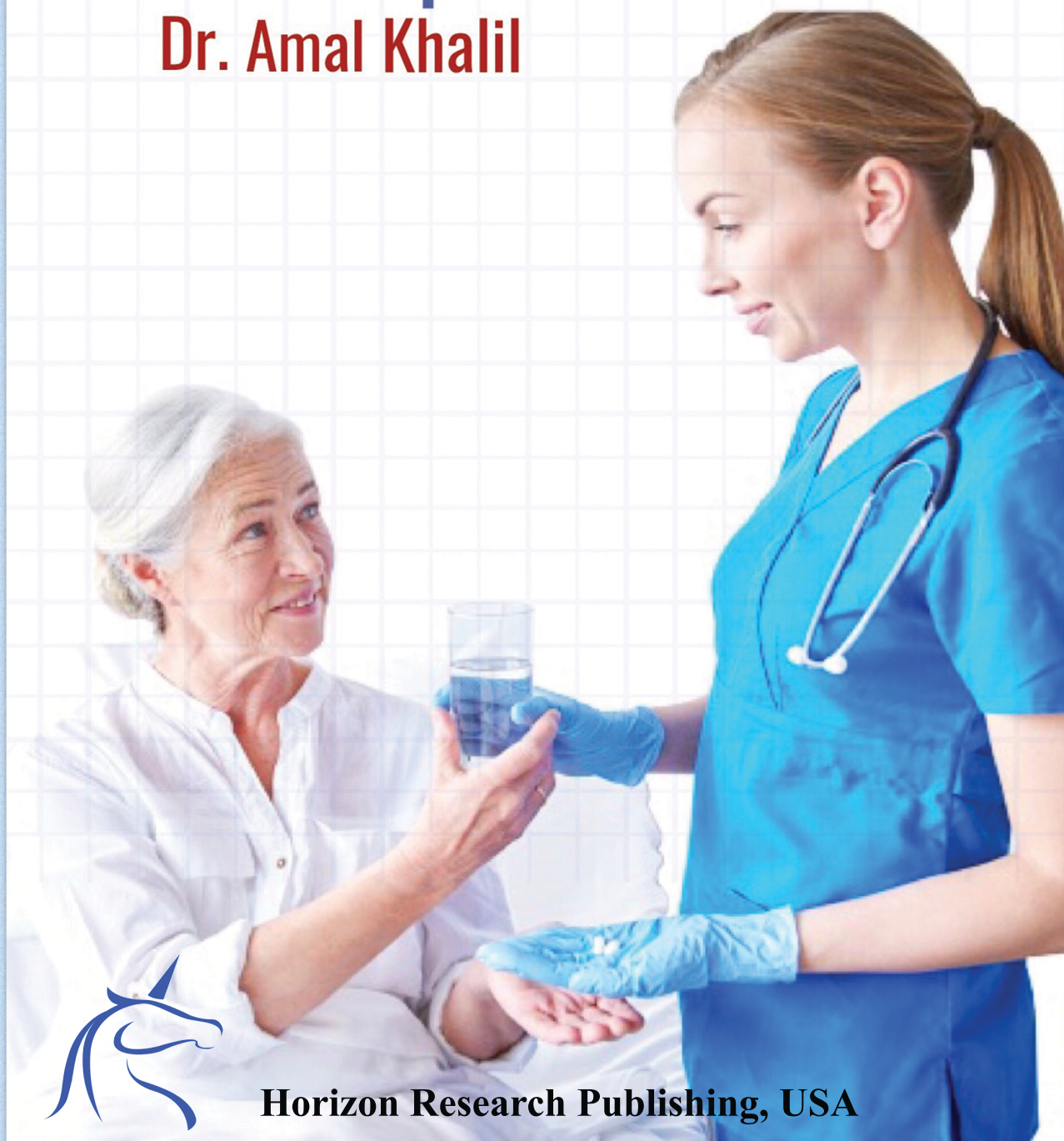
Manual of Psychiatric Nursing Competencies

by

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Introduction

This student manual is compiled to include the essential clinical nursing skills based on specific needs of the students to master the course content in Psychiatric Nursing. This is to be used exclusively in the clinical setting/skills lab for this course. This manual of psychiatric nursing competencies will fulfill an important requirement of the nurses in order to work with psychiatric patient.

The student manual provides up-to-date, evidence-based basic clinical skills related to the essential aspects of psychiatric patient care. The skills in this student manual are based on the latest research findings and directives from clinical experts. This will enable the students to be confident in their basic skills and lead them to be qualified nurses to provide the best possible care to their patients.

This manual is based on the four of the basics skills domains such as communication skills, nurse patient relationship, and ethical aspects and legal practices necessary to deal with psychiatric patients. The second part is concerned with components of clinical psychiatric assessment including history taking, and mental status examination. The third part is concerned with symptom management such as hallucination, delusion, suicide and aggressive patient management. The last part is concerned with treatment modalities involving medication, ECT, activity therapy and how to conduct psycho-education for psychiatric patient.

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1.1. Communication and Interviewing Skills

Interpersonal communication is the process by which people exchange information, feelings, and meaning through verbal and non-verbal messages: it is face-to-face communication. Interpersonal communication is not just about what is actually said - the language used - but how it is said and the non-verbal messages sent through tone of voice, facial expressions, gestures and body language. Communication is the main tool to assess, diagnose and to make an intervention.

In the transactional model, both participants perceive and, listen to each other, and simultaneously engage in the process of creating meaning in a relationship, whilst focusing on the patient's issues and assisting them to learn new coping skills. (Towensend, 2009)

The therapeutic milieu is a scientific structuring of the environment in order to effect behavioral changes and to improve the psychological health and functioning of the individual. The therapeutic milieu is also an important structure to interact with the pychiatric patient as within this structured environment, the client is expected to learn adaptive coping, interaction, and relationship skills that can be generalized to other aspects of his or her life. (Fakhr-Movahedi, Negarandeh, & Salsali, 2012)

Therapeutic communication consists of verbal and nonverbal techniques that focuses on the client's needs and promotes of healing and change. Additionally, it encourages the exploration of feelings and fosters understanding of behavioral motivation, promotes trust, discourages defensiveness, and is nonjudgmental. (Papadantonaki, 2012)

1.1.1. Context of therapeutic communication

1. Values, attitudes, and beliefs that govern communications <u>for example</u> Attitudes of prejudice are expressed through negative stereotyping.
Culture or religion

2. Cultural mores, norms, ideas, and customs provide the basis for ways of thinking for example Social status
High-status persons often convey their high-power position with gestures of hands on hips, power dressing, greater height, and more distance when communicating with individuals considered being of lower social status.

3. Gender: Masculine and feminine gestures influence messages conveyed in communication with others.

4. Age or developmental level: For example: The influence of developmental level on communication is especially evident during adolescence, with words

such as "cool," "awesome," and others.

5. Territoriality, density, and distance, are aspects of environment that communicate messages.

- Territoriality - the innate tendency to own space
- Density - the number of people within a given environmental space
- Distance - the means by which various cultures use space to communicate
- Proxemics: Use of space
- Intimate distance - the closest distance that individuals allow between themselves and other
- Personal distance -the distance for interactions that are personal in nature, such as close conversation with friends
- Social distance - the distance for conversation with strangers or acquaintances
- Public distance - the distance for speaking in public or yelling to someone some distance away

1.1.2. Nonverbal Communication: Body Language

1.1.3. Components of nonverbal communication

- Physical appearance and dress
- Body movement and posture
- Touch
- Facial expressions
- Eye behavior
- Vocal cues or paralanguage

Table (1) states some examples of therapeutic communication techniques that could be used with patients and will help the nurse in understanding patient's behavior, concerns, feelings and needs.

I. Therapeutic communication techniques that help the patient to express his needs and feelings:	
Offering self	The nurse offers his or her presence, interest, and desire to understand without making any demands on the patient. • *"We can sit here quietly; there's no need to talk unless you want to."* • *"I'll sit with you awhile."*
Active Listening	To listen actively is to be attentive to what client is saying, both verbally and nonverbally. Several nonverbal behaviors have been designed as facilitative skills for attentive listening. S – Sit squarely facing the client. O – Observe an open posture. L – Lean forward toward the client. E – Establish eye contact. R – Relax.
Giving Feedback	It is a reaction, without it, the sender of the message cannot know whether the recipient has received the entire message or grasped its intent. The need for feedback should be clearly understood. Feedback is useful when it is:

	• descriptive rather than evaluative and focused on the behavior rather than on the client • specific rather than general • directed toward behavior that the client has the capacity to modify • imparts information rather than offers advice • well timed
Offering general leads	i.e. encourages the client to continue
Placing the event in time or sequence	i.e. clarifies the relationship of events in time
Making observations	i.e. verbalizing what is observed or perceived or conveys concern and interest to the client while taking note of their behavior (e.g how they look, sound or act etc.). • "I see you are quite anxious." • "You keep rubbing you forehead; are you in discomfort.
Encouraging description of perceptions	i.e. asking client to verbalize what is being perceived
Asking Relevant Questions	i.e. Prompting patients to seek information by using: • Open-ended questions: to allow client to take the lead in the conversation and give information • Focused questions: used when more specific information is needed in an area. • Closed-ended questions: elicit a yes, no, or one-word response. Most often they block communication, but can be useful when conversation gets off track
Waiting in Silence	i.e. providing ample of time so that the client has time to verbalize feelings
Empathizing	•i.e. Understanding and accepting another person's reality, to accurately perceive feelings, and to communicate this understanding to others. Demonstrates warmth and acknowledges client's feelings Example: "That must have been very difficult for you."
Accepting	i.e. verbalizing positive cues such as : Yes. Uh hum. I follow what you said! Nodding
Sharing Feelings/emotions:	i.e. Assisting clients to share feelings by making observations, acknowledging feelings, encouraging communication, giving permission to express negative feelings and modeling healthy emotional self-expression.
Sharing Hope:	i.e. Communicating a sense of possibility.
II. Therapeutic techniques used to understand the client expression:	
Restating	Using different words to repeat the main idea the patient has expressed. For example: • Pt.: "I couldn't sleep all night." • Nurse: "You couldn't sleep all night." Or "You couldn't sleep all night?" • Pt.: "My husband is very worried about me." • Nurse: "Your husband is very worried about you." Or "Your husband is very worried about you?"
Clarifying	The nurse makes an effort to have the patient clarify comments

	that are vague. • *"You spoke so softly I did not hear what you said."* • *"I'm not able to follow that thought; could you tell me a little more about it?"*
Validating	"I'm having some difficulty. Could you help me understand?"
Humor	"That gives whole new meaning to the word nervous," (said with shared kidding between the nurse and the patient).
Presenting reality:	An effort is made to indicate what is real from unreal. Ex. Your mother is not here; I'm a nurse.
Summarizing:	A concise review of the main ideas that have been discussed. Ex. "From what you describe, your family seems…."
Paraphrasing	Restating another's message more briefly and in your own words; lets another know you are actively seeking understanding of what they are saying.
III. Therapeutic communication techniques that help to develop patients' self-awareness	
Focusing:	It is used to center on key elements or concepts of a message; used to guide direction of conversation to an important area. Ex. "You touched on his drinking. Tell me more about that."
Encouraging plan formation	It helps the client develop steps to make changes and solve problems
Confronting	The nurse supports the client but directly challenges inaction on the part of the client Ex. "You keep telling me that you want to quit drinking, but what actions have you taken thus far to aid with your sobriety?"
Encouraging evaluation	For example: "What are your feelings in regard to…? Does this contribute to your discomfort?"
Giving recognition	For example: I noticed that you've combed your hair
Verbalizing the implied	i.e An attempt to detect the true meaning of the implied verbal messages . For example : • Client: "My wife pushes me around just like my mother & sister do." • Nurse: "Is it your impression that women are domineering?"
Attempting to translate into feelings	For example : • Client: "I've been in the hospital for 6 weeks. I might as well be dead." • Nurse: "You think that you're not getting better?"
Encouraging comparison	i.e. Asking client to compare similarities and differences in ideas, experiences, or interpersonal relationships
Exploring	i.e. Delivering further into a subject, idea, experience, or relationship
Giving information	i.e. giving the patient facts or specific information that is needed Questions are answered simply and directed Examples: My name is... Visiting hours are ... My purpose in being here is...
Voicing doubt	For example: Isn't that unusual? Really? That's hard to believe.
Positive reinforcement	Ex. I see you are clean today Ex. I see you are dresses nicely
Setting Limit	i.e. approaching the patient with firm behavior , but accepting attitude , and rejecting the maladaptive behavior,but accepting the person

	For example. "Mr. D, I really enjoy playing monopoly with you, but I don't like when you swear. I am wondering if you can express your angry feeling in another manner. For example: Spitting in the floor is not accepted. Ex. Your loud voice is un accepted in communicating your concern.
Process Recordings	i.e. Writing reports of verbal interactions with clients. They are written by the nurse or student as a tool for improving communication techniques.

1.1.4. Non-therapeutic Communication Techniques

- Asking Personal Questions: personal questions that <u>are not relevant</u> to the situation are nosy and intrusive.
- Giving Personal Opinions: takes decision making away from client; imposes the health professional's ideas on the client
- Changing the Subject: shifts the focus of conversation from one topic to another unrelated topic; rude and shows lack of empathy.
- Automatic Response: trite phrases that move the focus away from the client, block expression of the client's ideas and feelings and interfere with the problem-solving process.
- False Reassurance: promises something that may not happen, says something that is untrue or attempts to provide comfort in an incongruent manner.
- Sympathy: focuses on the nurse's feelings rather than the client's.
- Asking for Explanations ("Why" questions): makes the client feel defensive and that they must give an explanation for their feelings or behavior.
- Approval or Disapproval: is judgmental behavior. It often invalidates the client's opinions or feelings.
- Defensive Response: occurs when the health professional supports some aspect of the health care system in response to a negative comment by a client.
- Passive or Aggressive Response:
  - Passive Responses: avoid conflict; and sidestep the topic: fail to explore feelings and thoughts with the client by stepping around the real issue.
  - Aggressive Responses: provoke confrontation at the other person's expense
- Arguing: challenging or arguing against perceptions denies that they are real and valid to the other person.

The table below showcases the items as well as the assessor guide for using therapeutic communication.

Chapter 2. Assessment Skills

2.1. History Taking

2.2. Mental State Examination (MSE)

2.1. History Taking

'The patient past psychiatric history' is a structured assessment conducted to generate a comprehensive picture of a patient's mental, social and physical health problems. Taking a disease history of a psychiatric patient requires skills necessary for examinations and diagnosis. It also provides feedback regarding the risk factors in the patient's life based on biopsychosocial assessment model. It tests both the communication skills as well as knowledge about what to ask. Specific questions vary depending on what type of history is taken but if follow the general framework stated below is followed, students will gain good marks in these stations. This also offers an opportunity to the student for presenting ones history. In practice, the students may sometimes need to gather a collateral history from a relative, friend or caregivers. This may be a child or an adult with an impaired mental state. The table below showcases the items as well as the assessor guide for history taking.

Chapter 3. Symptoms Management

3.1. Nursing Management of Patient with Hallucination

3.2. Nursing Management of Patient with Delusion

3.3. Nursing Management for Suicidal Patient

3.4. Nursing Management for Aggressive Patient

3.5. Physical Restraint Application

3.1. Nursing Management of Patient with Hallucination

Hallucination is defined as an alteration in perception without external stimuli. Perception is the process by which people translate sensory impressions into a coherent and unified view of the world around them. Though necessarily based on incomplete and unverified (or unreliable) information, perception is equated with reality for most practical purposes and guides human behavior in general.

Ohayon (2000) found that out of a sample of 13,000 adults, 38.7% reported experiencing hallucinations, 6.4% had hallucinations once a month, 2.7% had them once a week and 2.4% had them more than once a week.

It is evident that certain diseases or disorders are associated with specific types of hallucinations. Patients with a diagnosis of psychotic or anxiety disorders are more likely to suffer from visual and auditory hallucinations, while drug users are more likely to suffer from tactile hallucinations. Schneider and Dagerman (2004) stated that 40-50% of patients diagnosed with Alzheimer's disease developed hallucinations in the latter stages of the illness. It was also found that hallucinations in children are rarely experienced under the age of eight; however, approximately 40% of children diagnosed with schizophrenia suffer from visual or auditory hallucinations. The National Sleep Foundation (2007) supported studies in both the US and the UK (Ohayon, 2000), looking at people during normal sleep and wake cycles. They found that 30-37% of adults had experienced hypnagogic hallucinations, which occur just before falling asleep, and 10-12% of adults reported hypnopompic hallucinations, which occur as a person awakens.

There are different types of hallucination which may involve all five senses - hearing, sight, touch, taste, and smell. Although auditory and visual hallucinations are the most common ones experienced by patients, other types may affect different senses. These include touch, where the person has the feeling that creatures may be crawling over the skin (tactile hallucinations), experiencing a peculiar taste (gustatory hallucinations) or a peculiar smell (olfactory hallucinations). It must be remembered that although these experiences are not real to carers and nurses, they are very real to patients. Thus, it is important to relay to patients that you believe they are experiencing them. Auditory hallucinations shown by hearing one or more voices talking are associated with people with psychotic disorders, particularly schizophrenia. Florid hallucinations are associated with taking hallucinogenic drugs, sleep deprivation or neurological illness.

The nurse's role is crucial since people experiencing hallucinations may also have disturbed thoughts and may become disinterested in others and their surroundings. They may also find it difficult to maintain interpersonal skills and

Chapter 4. Treatment Modalities

4.1. Non-pharmacological: Activity Therapy

4.1.1. Activity Done with Psychiatric Patient

4.1.2. Occupational therapy

4.1.3. Animal Assisted therapy

4.1.4. Recreational therapy

4.1.5. Industrial therapy

4.1.6. Bibliotherapy

4.1.7. Music therapy

4.2. Conducting Psycho-education

4.3. Pharmacological Treatment Modalities

4.4. Somatic Therapies

4.1. Non-pharmacological: Activity Therapy

4.1.1. Activity Done with Psychiatric Patient

Activity therapy is medically prescribed and professionally guided programs of work and play for individuals as well as in groups. In this unique treatment, the client chooses an activity, such as game or sport. Then it becomes part of the therapy as client and therapist build a relationship around the activity.

<u>Aim of Activity Therapy</u>

1. To help patients develop self – esteem.
2. To provide suitable outlets for aggression and excess energy for the Disturbed patient.
3. They develop social skills and improve communication with others through the creation of a social atmosphere.
4. To promote and enhance quality of life
5. To enhance or maintain physical and cognitive abilities
6. To promote emotional and psychosocial well-being
7. To offer opportunity for creative expression, decision making, choice, and responsibility
8. To offer relaxation and promote independence
9. To provide opportunity for fun, enjoyment, common interests and experiences
10. To provide opportunity to learn new skills, or adapt old skills

How to Choose the Appropriate Activity Therapy for Patients

- According to physician written order
- According to patient's age, sex,
- Mental disorders stage, severity, chronicity and acuteness.
- Physical ability and capacity to participate.

General Principles Guiding the Activity Therapy

1. Patients must be brought to the highest possible degree of physical, mental, social and economic.
2. Patient's socialization and to assist him in the development of the new personal relationship.
3. To improve his adjustment to hospital life
4. Type of therapy must be adjusted to patient needs
5. Provide a sense of achievement.
6. Outlets for suppressed or repressed emotions.

4.2. Conducting Psycho-education

- ***Psychoeducation*** refers to the process of providing education and information to those seeking or receiving mental health services, such as people diagnosed with mental health conditions (or life-threatening/ terminal illnesses) and their family members.

  http://www.aipc.net.au/articles/psychoeducation-definition-goals-and-methods

The Purpose of Psychoeducation is

- Help people better understand (and become accustomed to living with) mental health
- Reduce rehospitalization rates and decrease the number of days a person spends in the hospital.
- Increased compliance with treatment regimens through developing patients' orientation regarding the positive and negative effects of any psychotropic medications
- Plays a vital role in the DE stigmatization of mental health conditions.

Understanding the Process and format of Psychoeducation:

Psychoeducation may be offered in both individual and group formats, it can benefit the individual who is diagnosed, parents and other family members,as well as caregivers and friends. It is not an approach to treatment in itself but represents an important early step in treatment of psychiatric patients. Psychoeducation may be general or highly specified and can be provided in a number of ways, though it is broadly steered by four main goals: transfer of information, medication and treatment support, training and support in self-help and self-care, and the provision of a safe place to vent emotional frustrations. (Reyes, 2010)

All of the Following May Constitute Psychoeducation:

- **Individual base:** as when the nurse explains the ways a mental health condition might impact patient's function or, a psychiatrist describing how a prescribed medication can counteract symptoms of a mental health condition
- **Group format:** such as a psychiatric hospital providing support and education to family members of those receiving treatment through:

  - Formal classes designed to educate the population about both specific mental health conditions and mental health in general

4.3. Pharmacological Treatment Modalities

Psychotropic Medication Education

Psychotropic drugs are prescribed to treat a variety of mental health issues when those issues cause significant impairment to healthy functioning. Psychotropic drugs typically work by changing or balancing the number of important chemicals in the brain called neurotransmitters. Some mental health issues show improvement when neurotransmitters such as dopamine, serotonin, and norepinephrine are increased or decreased. Psychotropic drugs are usually prescribed by a psychiatrist, a psychiatric nurse practitioner (PMHNP), or a primary care physician; in some areas, clinical psychologists may have prescriptive privileges as well.

Certain individuals who are prescribed psychiatric medications may prefer not to take them, or they find that these medications do not improve their symptoms enough to outweigh any side effects or risks. A cause of concern to many is the practice of prescribing medications that were originally developed for adults to children. The increase in diagnoses of psychiatric conditions in children---bipolar in particular---has led to an increase in the number of children who take psychiatric medications, some of which have only been fully tested in adults. Though these medications have been shown to help relieve at least some symptoms in minors, at least for the short-term, questions have been raised about the long-term effects that some of the medications might have on developing children and whether these children actually have conditions that were originally thought to only exist in adults.

Types of Psychotropic Medications

Several different types of medications are used to treat mental health conditions. The following is a list of the major categories of psychotropic medications:

Antipsychotics: These medications are most often prescribed for the treatment of psychotic issues such as schizophrenia. These drugs fall into two categories, typical such as; Stelazine (trifluoperazine), Prolixin (fluphenazine), Moban (molindone), Mellaril (thioridazine) and Haldol (haloperidol) and atypical antipsychotics include: Abilify (aripiprazole), Clozaril (clozapine),Geodon (ziprasidone),Risperdal (risperidone) ,Seroquel (quetiapine),and Zyprexa (olanzapine) .

Antidepressants are a broad category of psychotropic drugs used for treating

4.4. Somatic Therapies

Somatic therapy is one of the best ways to help patients suffering from psychological traumas in order to cope, recover and lead a normal life. In some cases, past traumas may manifest physical symptoms like pain, digestive issues, hormonal imbalances, sexual dysfunction and immune system dysfunction, medical issues, depression, anxiety, and addiction.

Types of Somatic Therapy:

- Electro Convulsive Therapy (ECT)
- Phototherapy
- Sleep deprivation

Electroconvulsive Therapy (ECT)

Electroconvulsive therapy (ECT) is a somatic therapy done under general anesthesia, in which small electric currents are passed through the brain, intentionally triggering a brief seizure. ECT seems to cause changes in brain chemistry that can quickly reverse symptoms of certain mental illnesses. ECT often works when other treatments are unsuccessful and when the full course of treatment is completed, but it may not work for everyone. It often works when other treatments are unsuccessful.

It is an artificially induced Seizure with voltage 110-170 run through patient mind or brain with 2 electrolyte electrodes applied either unilateral or bilateral for 0.3-0.5 min)

Much of the stigma attached to ECT is based on early treatments in which high doses of electricity were administered without anesthesia, leading to memory loss, fractured bones, and other serious side effects. ECT is much safer today. Although ECT still causes some side effects, it now uses electric currents given in a controlled setting to achieve the most benefit with the fewest possible risks.

ECT is done through using 2 electrodes applied unilateral or bilateral (on both temples) through electric currents voltage 70-110 volts for 0.2 to 0.5 minutes to change the mood.

ECT is effective to treat patients who are:

- Acutely suicidal.
- Mood disorders especially Major Depressive Disorder (MDD)even in elderly people.
- Bipolar Disorder (Mania)

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