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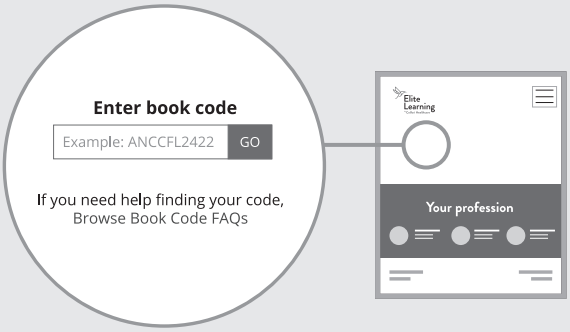

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- Submissions without a valid e-mail will be mailed to the address provided.

Basic Psychiatric Concepts

6 Contact Hours

Release Date: June 1, 2022 **Expiration Date:** June 1, 2025

Faculty

Robyn B. Caldwell, DNP, FNP-BC, earned a Doctor of Nursing Practice (DNP) from Samford University in nursing administration with an emphasis in nursing education in 2013; a post-master's certificate as a family nurse practitioner from Delta State University in 2003; a master's degree in Nursing Administration (MSN) in 1996; and Bachelor of Science in nursing (BSN) degree in 1990 from the University of Tennessee. Dr. Caldwell has worked in a variety of healthcare settings throughout her 32-year career including adult and pediatric emergency nursing, nursing administration, and nursing education (LPN to DNP) in both the community college and university settings. She has published and presented on topics relevant to nursing education and patient outcomes in local, state, and national venues. Currently, Dr. Caldwell is employed in an urgent care setting and is working on a post masters as a psychiatric mental health nurse practitioner (PMHNP).

Robyn B. Caldwell has disclosed that she has no significant financial or other conflicts of interest pertaining to this course.

Reviewer: Kimberleigh Cox, DNP, PMHNP-BC, ANP-BC, PHNc., is an Associate Professor at the University of San Francisco's School of Nursing and Health Professions and is nationally board certified as both an adult nurse practitioner (ANP) and psychiatric mental health nurse practitioner (PMHNP). She is also a certified Public Health Nurse (PHNc). Dr. Cox received her bachelor's degree in Psychology from Brown University. She then worked for Harvard, Brown and Stanford Universities' Departments of Psychiatry and Mood Disorders Clinics from 1990-1995 doing clinical research, primarily in depressive and anxiety disorders. Dr. Cox received her master's degree in Nursing (MSN) from University of California San Francisco in 1998, completing a dual adult and psychiatric nurse practitioner program. She has practiced clinically as a Nurse Practitioner since 1998 working with diverse populations of individuals with psychiatric, behavioral health, and addictive problems in a variety of specialty mood disorders, psychiatric and residential care settings in California. She completed her Doctor of Nursing Practice (DNP) from USF in 2010 and was the Dean's Medal recipient for professionalism. Her doctoral work focused on chronic depression and the application of an evidence-based psychotherapeutic treatment. Dr. Cox has been teaching undergraduate and graduate nursing students in community/public health and psychiatric/mental health since 2003. She has presented nationally on managing patients with difficult behaviors, has authored publications, including "Bipolar and Related Disorders: Signs, Symptoms and Treatment Strategies" (2018), and has peer reviewed "Depression: A Major Public Health Concern" (2nd & 3rd editions - 2019, 2022).

Kimberleigh Cox has disclosed that she has no significant financial or other conflicts of interest pertaining to this course.

Course overview

The goal of this course is to provide an introductory overview of mental health concepts. This course examines the history, epidemiology, legal/ethical aspects, mental health assessment, and other basic therapeutic skills used in mental health nursing. In-text links, case studies, and self-assessment questions and NCLEX-style testing are utilized.

This course is designed for registered nurses, licensed practical/vocational nurses, and newly licensed registered nurses who desire a greater understanding of basic mental health concepts. A fundamental understanding of medical terminology, abbreviations, and nursing care is assumed.

Learning objectives

Upon completion of the course, the learner will be able to:

- Explore historical aspects associated with mental healthcare.
- Identify legal and ethical principles of mental health nursing.
- Explore cultural aspects of mental health.
- Describe components of the psychiatric assessment, including the mental status exam.
- Describe neurobiological components essential to mental health.
- Identify therapeutic modalities used in mental healthcare.

How to receive credit

- Read the entire course online or in print which requires a 6-hour commitment of time.
- Complete the self-assessment quiz questions which are at the end of the course or integrated throughout the course. These questions are NOT GRADED. The correct answer is shown after you answer the question. If the incorrect answer is selected, the rationale for the correct answer is provided. These questions help to affirm what you have learned from the course.
- Depending on your state requirements you will be asked to complete either:
  - An affirmation that you have completed the educational activity.
  - A mandatory test (a passing score of 70 percent is required). Test questions link content to learning objectives as a method to enhance individualized learning and material retention.
- If requested, provide required personal information and payment information.
- Complete the MANDATORY Course Evaluation.
- Print your Certificate of Completion.

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Individual state nursing approvals

Colibri Healthcare, LLC is accredited as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation. In addition to states that accept courses offered by ANCC accredited Providers, Colibri Healthcare, LLC is an approved Provider of continuing education in nursing by: Alabama Board of Nursing, Provider #ABNP1418 (valid through February 5, 2025); Arkansas State Board of Nursing, Provider #50-4007; California Board of Registered Nursing, Provider #CEP17480 (valid through January 31, 2024); California Board of Vocational Nursing and Psychiatric Technicians (LVN Provider #V15058, PT Provider #V15020; valid through December 31, 2023); District of Columbia Board of Nursing, Provider #50-4007; Florida Board of Nursing, Provider #50-4007; Georgia Board of Nursing, Provider #50-4007; Kentucky Board of Nursing, Provider #7-0076 (valid through December 31, 2023; CE Broker Provider #50-4007); Michigan Board of Nursing, Provider #50-4007; Mississippi Board of Nursing, Provider #50-4007; New Mexico Board of Nursing, Provider #50-4007; North Dakota Board of Nursing, Provider #50-4007; South Carolina Board of Nursing, Provider #50-4007; and West Virginia Board of Registered Nurses, Provider #50-4007. This CE program satisfies the Massachusetts States Board's regulatory requirements as defined in 244 CMR5.00: Continuing Education.

Activity director

Deborah Martin, DNP, MBA, RN, NE-BC, FACHE, Director of Learning Innovation Colibri Healthcare, LLC

Disclosures

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The information provided in this activity is for continuing education purposes only and is not meant to substitute for the independent medical judgment of a healthcare provider relative to diagnostic and treatment options of a specific patient's medical condition.

Course verification

All individuals involved have disclosed that they have no significant financial or other conflicts of interest pertaining to this course. Likewise, and in compliance with California Assembly Bill No. 241, every reasonable effort has been made to ensure that the content in this course is balanced and unbiased.

INTRODUCTION

In 1973, the American Nurses Association (ANA) developed standards as a framework for psychiatric-mental health nursing practice, which evolved into the "Psychiatric-Mental Health Nursing: Scope and Standards of Practice" (2nd edition, 2014). These practice guidelines provide a foundation for standardization of the professional role, scope, and standards of practice for psychiatric-mental health nurses. During the 1980s and 1990s, respectively, the American Nurses Credentialing Center (ANCC) and American Association of Nurse Practitioners (AANP) implemented specialty certifications relevant to the level of education and experience of the applicants. Increasing numbers of psychiatric mental health nurse practitioners (PMHNPs) have obtained certification to provide advanced care to individuals in both acute and community health settings.

HISTORY OF MENTAL HEALTHCARE

Before the late 1800s, unusual behaviors were commonly thought to be caused by demonic forces. Those who displayed strange behaviors were often banished or confined. People with these odd behaviors were treated poorly and the treatments were aggressive and torturous. In the late 1700s, Philippe Pinel became the superintendent of a mental institution in France (Keltner, 2015). He noted the substandard conditions of the institution and the brutal treatment of the patients. He was the first to begin what became known as *moral therapy*, which consisted of better treatment, including unchaining patients and allowing them time outside. Soon after, William Tuke founded a similar facility in England (Boyd, 2018; Kibria & Metcalfe, 2016). This facility was based on the religious teachings of the Quakers and ensured moral treatment. Tuke saw this institution as a refuge for those with mental illness.

In the United States, Dorothea Dix, a Boston school teacher, was instrumental in opening a state hospital that endorsed a warm and caring environment, providing food and protection for Massachusetts residents (Boyd, 2018; Forrester, 2016). This facilitated a movement toward a more humanistic view of those with mental illness.

In the late 1800s and early 1900s, Sigmund Freud developed his landmark work regarding how childhood experiences and faulty parenting shape the mind (Boyd, 2018; Fromm, 2013). This began the movement toward scientific reasoning and understanding behaviors. Freud influenced researchers such as Carl Jung and Alfred Adler as well as other researchers who contributed to the fields of behaviorism, somatic treatments, and biology (Wedding & Corsini, 2020). With these new

developments, patients with psychiatric disorders began to receive needed psychiatric treatment and rehabilitation.

In 1946, the United States passed the National Mental Health Act, which resulted in the establishment of the National Institute of Mental Health or NIMH. In the second half of the 20th century, equality became a central tenet in mental health treatment. Many mental healthcare consumers became advocates and began to promote the rights of those with mental illness, working to demolish stigma, discrimination, and forced treatments.

In 1979, the National Alliance on Mental Illness, an advocacy group, was formed. Through the work of the alliance and other advocacy efforts, mental health patients were granted autonomy and began participating in their own care.

The 1990s were known as the *decade of the brain*, with focus placed on neuroscience and brain research.

It stimulated a worldwide growth of scientific research and advances, including the following:

- Research on genetic basis for mental illnesses.
- Mapping of the genes involved in Parkinson, Alzheimer's, and epilepsy.
- Discovery of the actions and effects of neurotransmitters and cytokines.
- Advancements in neuroimaging techniques that have increased our understanding of normal brain function and pathologic states (Halter, 2018).

In 1990, the Human Genome Project began to map the human genome. This 13-year project strengthened the theory that there are biological and genetic explanations for psychiatric conditions (https://www.genome.gov/human-genome-project). Although researchers have begun to identify genetic links to mental illness, research has yet to reveal the exact nature and mechanisms of the genes involved. It has been established, however, that psychiatric disorders can result from multiple mutated or defective genes.

EPIDEMIOLOGY

Epidemiology is the scientific study of the distribution (frequency, pattern) and determinants (causes, risk factors) of health-related states and events (not just diseases) in specified populations including neighborhoods, schools, cities, states, countries, and globally (https://www.cdc.gov/). Concepts related to epidemiology include *incidence* and *prevalence*. Applied to mental health, incidence is the number of new cases of a mental disorder in each period. Prevalence is the total number of cases in each population for a specific period. According to 2019 data from the National Institutes of Mental Health (NIMH), an estimated 51.5 million adults aged 18 or older (20.6%) in the United States have been diagnosed with mental illness. Lifetime prevalence estimates 49.5% of adolescents have been diagnosed with a mental disorder and 22.2% have had severe impairment (NIMH).

POLICY AND PARITY

The first Surgeon General's report on mental health was published in 1999. This landmark report, which was based on scientific literature and included a focus on mental health providers and consumers, concluded that mental health is fundamental to holistic health and that effective treatments for mental disorders are available.

In 2003, the President's New Freedom Commission on Mental Health recommended that the healthcare system needed to streamline care for those suffering from mental illness. This commission advocated for early diagnosis, prevention, and treatment and set forth new expectations for recovery and assistance for those experiencing mental illness to find housing and work.

In 2006, the Institute of Medicine (now the Health and Medicine Division of the National Academies) Committee on Crossing the Quality Chasm published Improving the Quality of Health Care for Mental and Substance Use Conditions. The *Quality Chasm* series highlights effective treatments and addresses large gaps in care, focusing on voluntary treatment. Additionally, this promotes a system that treats mental health issues separately from physical problems. A strong recommendation was made for equality in financial reimbursement and quality treatment. *The Mental Health Parity and Addiction Equity Act of 2008* (Office of the Federal Register, 2013) sought to improve the quality of treatments for those with mental illness by advocating mental health coverage at the same annual and lifetime benefit as any medical-surgical coverage (Centers for Medicare & Medicaid Services, n.d.). This Act required any business with more than 50 employees to have mental health coverage at the same level as medical-surgical coverage (Centers for Medicare & Medicaid Services, n.d.). This includes deductibles, copayments, coinsurance, out-of-pocket expenses, and treatment limitations. The requirements under the Act are applied indirectly to small group health plans in tandem with the Affordable Care Act's essential health benefit requirements (Centers for Medicare & Medicaid Services, n.d.).

PSYCHIATRIC AND MENTAL HEALTH NURSING

The psychiatric nurse *promotes mental health through the assessment, diagnosis, and treatment of human responses to mental health problems and psychiatric disorders* (American Nurses Association, 2014, p. 129). Psychiatric nursing integrates the use of self, neurobiological theories, and evidence-based practice in planning treatments. Nurses work in a variety of inpatient and outpatient settings with individuals and families across the lifespan who exhibit mental health needs. Specific activities of the psychiatric nurse are defined by the Psychiatric-Mental Health Nursing: Scope and Standards of Practice, published jointly by the American Nurses Association, the American Psychiatric Nurses Association, and the International Society of Psychiatric Mental Health Nurses (American Nurses Association, 2014).

Nurses encounter patients in crisis in many clinical settings. The crisis may be physical, emotional, mental, or spiritual. Regardless of the origin, these patients express a variety of feelings including hopelessness, helplessness, anxiety or anger, low self-esteem, and confusion. Many individuals act withdrawn, suspicious, depressed, hostile, or suicidal. Additionally, the individual may be intoxicated or withdrawing from alcohol or other substances. Knowledge of basic psychiatric concepts increases nursing competency in any clinical setting.

DSM-5 NOMENCLATURE FOR DIAGNOSES AND CLASSIFICATIONS

Blood tests, though useful for diagnosing many physical disorders, cannot diagnose all psychiatric disorders. Instead, healthcare practitioners base their diagnoses primarily on symptoms. Emil Kraepelin was the first healthcare provider to recognize and categorize patients' symptoms into mental disorders around the turn of the 20th century (Boyd, 2018).

Today, healthcare providers often use other forms of tests, such as genetic testing, computerized tomography, magnetic resonance imaging, and positron emission tomography, to detect changes in the brain and brain activity.

By 1880, researchers had developed seven classifications of mental illness: mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsy (APA, n.d.). By 1918, the need for uniformity in diagnoses drove the Committee on Statistics of the American Medico-Psychological Association, which later became the American Psychiatric Association (APA, 2013), to develop the first *Statistical Manual for the Use of Institutions for the Insane*. The purpose of this document was to gather statistical information from institutions regarding 22 known disorders. Following World War II, US Army psychiatrists expanded the diagnostic categories to better incorporate the types of problems veterans experienced as a result of combat (APA, n.d.).

In 1952, the APA published the first edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. Since then, the APA has published new editions of the DSM every 5 to 10 years. In 2013, the APA released the fifth edition of the DSM, the most recent version (APA, 2013). The DSM-5 is the result of a 12-year revision process involving hundreds of professionals, field trials to demonstrate the reliability of the data, and public and professional review and comment (APA, 2013).

The purpose of the DSM-5 is to facilitate healthcare providers' diagnosis of mental disorders and development of individualized treatment plans (APA, 2013). The DSM-5 bases disorders on a continuum from mental health to mental illness. A mental disorder is defined in the DSM-5 as *a syndrome characterized by clinically significant disturbance in the individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning* (APA, 2013, p. 20). The definition also reflects the high level of disability or distress in occupational or other life activities that results from the mental disorder.

Some healthcare providers feel that the DSM-5's categorical classifications limit its use because individuals may not fit neatly into one specific category. Regardless, the DSM-5 serves as a guideline to assist practitioners in making sound clinical decisions. Diagnosis does not always imply etiology; therefore, using the DSM-5 to predict behavior or response to treatment is inappropriate (APA, 2013).

THEORIES RELATED TO PSYCHIATRIC AND MENTAL HEALTH NURSING

Mental health professionals base their work on assessments, behaviors, and theories. These are often described as explanations or hypotheses and tested for relevance and soundness. In mental health, theories are often borrowed from other disciplines and inspire treatments for the practice of psychiatric nursing.

Freud's psychoanalytic theory

Sigmund Freud, referred to as *the father of psychoanalysis*, revolutionized thinking about mental disorders (Townsend, 2019). His theories of personality structure, level of awareness, anxiety, the role of defense mechanisms, and stages of psychosexual development revolutionized the psychiatric world (Townsend, 2019). Although Freud started as a biological scientist, he changed his approach to conversational therapy. He concluded that talking about difficult issues involving intense emotions had the potential to heal problems that could cause mental illnesses. This led Freud to develop his psychoanalytic theory (https://pmhealthnp.com/pmhnp-topics/sigmund-freud-psychoanalytic-theory/).

Erikson's theory on the stages of human development

Erik Erikson, a developmental psychologist, emphasized the role of the psychosocial environment and expanded on Freud's psychoanalytic theory. The Eight Stages of Man, is organized by age and developmental conflicts:

1. Basic trust versus mistrust.
2. Autonomy versus shame and doubt.
3. Initiative versus guilt.
4. Industry versus inferiority.
5. Identity versus role confusion.
6. Intimacy versus isolation.
7. Generativity versus stagnation.
8. Ego integrity versus despair.

Analysis of behavior using Erikson's framework helps nurses to identify long term successful resolution of psychosocial development across the lifespan.

Harry Stack Sullivan's interpersonal theory

Interpersonal theories are the cornerstone of mental health nursing. Harry Stack Sullivan, an American-born psychiatrist, identified personality as an observable behavior within interpersonal relationships, which led to the development of his interpersonal theory. Sullivan believed that anxiety or painful feelings arise from insecurities or the inability to meet biological needs. All behaviors are designed to help individuals through interpersonal interactions by decreasing anxiety. Individuals are unaware that they act out behaviors to decrease anxiety and therapy can help the patient gain personal insight into these insecurities. He was the first to use the term *participant observer*, which refers to the idea that therapists must be part of the therapeutic session. Sullivan insisted that healthcare professionals should interact with patients as authentic human beings through mutual respect, unconditional acceptance, and empathy. Sullivan developed the concept of psychotherapeutic environments characterized by accepting the patient and the situation, which has become an invaluable treatment tool. Even today, many group psychotherapies, family therapies, and training programs use Sullivan's design of an accepting atmosphere (Halter, 2018).

Hildegard Peplau's theory of interpersonal relations

Hildegard Peplau, sometimes referred to as the *mother of psychiatric nursing*, published the theory of interpersonal relations in 1952, which became a foundation for modern psychiatric and mental health nursing (Townsend, 2019). The goal of interpersonal therapy is to reduce or eliminate psychiatric symptoms by improving interpersonal functioning (Sadock, & Ruiz, 2015). Sullivan's work greatly influenced Peplau. She developed the first systematic framework for psychiatric nursing, focusing on the nurse-patient relationship. Peplau established the foundation of professional practice for psychiatric nurses and continued working on psychiatric nursing theory and advancement of nursing practice throughout her career. She was the first nurse to identify mental health nursing as a specialty area with specific ideologies and principles, and the first to describe the nurse-patient relationship as the foundation for nursing practice (Boyd, 2018).

Peplau created a major shift from a care model focused on medical treatment to one based on the interpersonal relationship between nurses and patients. She further proposed that nurses are both participants and observers in the therapeutic treatment of patients. Her theory recognizes the *ability to feel in oneself the feelings experienced by another*; she identified this as *empathetic linkage* (Boyd, 2018). Another key concept, according to Peplau, is anxiety, which is an energy that arises when present expectations are not met (Boyd, 2018). Throughout her career, Peplau's goal was for nurses to care for the person and the illness.

B.F. Skinner's behavioral theory

Behavioral theories supply techniques that patients can use to modify or replace behaviors. This is an important concept in psychiatric nursing management and is the basis of several approaches that research has shown to be successful in altering specific behaviors. B. F. Skinner, a prominent behaviorist, researched *operant conditioning*, the process through which consequences and reinforcements shape behaviors. Behavioral therapy is grounded in the assumption that maladaptive behaviors can be changed, and positive and negative reinforcements can be used to help modify behavior.

Behavioral therapy is often used in treating people with phobias, alcoholism, and anxiety. Another type of behavioral therapy is modeling, in which the therapist or nurse role-plays specific behaviors so that the patient can learn through imitation. Role-playing allows the patient to practice modeled behaviors in a safe environment. Another form of behavioral therapy is systematic desensitization, which targets a patient's specific fears and proceeds in a step-by-step manner to alleviate those fears with the help of relaxation techniques (Keltner, 2018).

Aaron Beck's cognitive behavioral therapy

Whereas behaviorists focus on the belief that behaviors can be changed, other researchers focus on cognition or thoughts involved in behaviors. Aaron Beck developed cognitive behavioral therapy after working with depressed patients. Cognitive behavioral therapy is based on cognitive psychology and behavioral therapy. Beck believed that depression was the result of distorted thinking processes and negative self-concept (https://www.ncbi.nlm.nih.gov/books/NBK470241/). Using this approach, the nurse can help the patient identify negative thought patterns and then help the patient recondition these cognitive distortions into more appropriate beliefs that are based on facts (https://www.ncbi.nlm.nih.gov/books/NBK470241/).

Humanistic Theories

Humanistic theories focus on the potential and the free will of patients. These theories emphasize self-actualization, the highest potential and productivity that an individual can achieve in life. For example, Abraham Maslow believed that motivation is driven by a hierarchy of needs that leads to becoming the best person possible. This model allows the nurse to work with the patient to create an individualized care plan based on the current hierarchical needs of the patient https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4130906/.

THE STRESS-DIATHESIS MODEL

The Stress-Diathesis Model was originally developed to explain schizophrenia during the 1960s, but later adapted to study depression during the 1980s (Colodro-Conde, et.al, 2018). According to this model, stress activates certain vulnerabilities (diathesis), which predisposes the individual to psychopathology. This model has been criticized for its vagueness, yet these principles are used to understand other psychiatric disorders.

BIOLOGICAL MODEL

Mental health nurses also attend to the physical needs of psychiatric patients. The nurse may administer prescribed medication, nutrition, and hydration to ensure optimal physiological functioning of the patient. The biological model of mental illness focuses on the chemical, biological, and genetic makeup of mental illness. This model seeks to understand how the body and brain interact to create experiences and emotions, and how social, environmental, cultural, spiritual, and educational factors influence individuals (Halter, 2018). All the theories discussed in this section play a vital role in how the nurse cares for the patient with a mental health disorder.

Self-Assessment Quiz Question #1

Which best describes Aaron Beck's Contribution to the mental health profession?

a. Hierarchy of needs.
b. Cognitive behavioral therapy.
c. Empathetic linkages.
d. Operant conditioning.

ETHICAL, LEGAL, AND CULTURAL CONSIDERATIONS

The term *ethics* refers to an individual's beliefs about right and wrong and societal standards regarding right and wrong. Bioethics refers to ethical questions related specifically to healthcare (Halter, 2018).

Ethics are linked to cultural values. Societal standards and values can be determined only within a specific group. However, fundamental principles of ethics exist in all cultures and are inherent in all human beings. Understanding how cultures view mental illness and the accompanying patient symptoms can influence how decisions, particularly ethical decisions, are made. Nurses can be an instrumental part of effective decision making when cultural values and societal standards differ.

A thorough understanding of general ethical principles is necessary to make reasonable, fair, and sound judgments in providing care. Nurses who choose to work in the specialty of mental healthcare will encounter ethical questions on almost a daily basis. Issues such as autonomy, confidentiality, patient protection, therapeutic relationships, mental health competency, and mental health admissions are particularly complicated. To better guide the nurse in making ethical choices, an understanding of the American Nurses Association Code of Ethics and the five basic principles of bioethics is useful.

American Nurses Association Code of Ethics

The American Nurses Association (ANA) established an ethical standard for the nursing profession that guides ethical analysis and decision making (ANA, 2015). Ethics is a branch of philosophy where one reflects on morality, which is the person's character, values, and conduct in a particular situation (ANA, 2015).

The Code of Ethics is the foundation for nursing theory and practice where values and obligations shape the nursing profession (ANA, 2015). This living document changes based on nursing's social context, with a revision occurring at minimum every 10 years (ANA, 2015). The ANA Code divides ethical issues into nine provisions, based on general ethical principles:

- Provision 1
  - The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person, including self-determination (ANA, 2015).
- Provision 2
  - The nurse's primary commitment is to the patient, whether an individual, family, group, community or population (ANA, 2015).

- Provision 3
  - The nurse promotes, advocates for, and protects the rights, health, and safety of the patient (ANA, 2015).
- Provision 4
  - The nurse has authority, accountability, and responsibility for nursing practice, makes decisions, and takes action consistent with the obligation to promote health and to provide optimal care (ANA, 2015).
- Provision 5
  - The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, persevere wholeness of character and integrity, maintain competence and continue personal and professional growth (ANA, 2015).
- Provision 6
  - The nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions and employment are conducive to safe, quality care (ANA, 2015).
- Provision 7
  - The nurse, in all roles and settings, advances the profession through research and scholarly inquiry, professional standards development, and the generation of both nursing and health policy (ANA, 2015).
- Provision 8
  - The nurse collaborates with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities (ANA, 2015).
- Provision 9
  - The profession of nursing, collectively through its professional organizations, must articulate nursing values, maintain the integrity of the profession and integrate principles of social justice into nursing and health policy (ANA, 2015).

The ANA Code may be viewed at no charge on the ANA website (https://www.nursingworld.org/coe-view-only).

Bioethical principles

Bioethics is a branch of ethics that studies the implications of biological and biomedical advances and can be considered a set of guiding principles for the nursing profession that go beyond right and wrong. Bioethical principles fall into five categories (Boyd, 2018; Halter, 2018). These principles are meant to be guidelines to help all clinicians in decision making.

- *Beneficence*: Clinicians have a duty to assist the patient to achieve a higher level of well-being. This concept encompasses kindness and generosity toward the patient in providing care. An example of this is changing healthcare policy or making sure a patient brought to the emergency department in severe pain gets medication as soon as possible.
- *Fidelity*: Healthcare providers have a duty to be honest and trustworthy. This concept includes loyalty, advocacy, and a commitment to the patient. An example of this is staying abreast of best practices in nursing or advocating for the patient to receive high-quality services. Another example is being faithful in your promises to check on a patient within a specific timeframe.
- *Autonomy*: The healthcare provider acknowledges the patient's right to make their own decision, even if the nurse disagrees with the decision. An example of this is a patient with cancer who refuses treatments that may prolong their life.
- *Justice*: Healthcare providers must recognize that all persons are entitled to equal treatment and quality of care. For example, it can be particularly difficult to provide emotional support and counseling equally to both the family harmed by an intoxicated driver and to the driver. Healthcare providers should strive to be nonjudgmental and fair to all patients, regardless of age, gender, race, sexual orientation, diagnosis, or any other differentiating characteristic.
- *Veracity*: The healthcare provider should always be truthful with the patient. This allows the patient to make informed decisions about their treatment. For example, talking to the patient about the side effects of medications is showing respect to the patient by being truthful.

Self-Assessment Quiz Question #2

Patients admitted to inpatient psychiatric units are scheduled for group therapy two times daily. Attendance is strongly encouraged, but not mandatory. Which ethical principle is demonstrated by this unit policy?

a. Autonomy.
b. Justice.
c. Beneficence.
d. Veracity.

IMPORTANT LEGISLATION IN MENTAL HEALTH

Section 1 of the 14th Amendment to the US Constitution adopted on July 9, 1868, states:

> *All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. No state shall … deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws* (U.S. Constitution). The issue of liberty has been tested repeatedly in the courts in cases in settings where U.S. citizens have been held against their will, including in psychiatric institutions.

Keltner and Steele (2018) provide an overview of landmark legal decisions related to patients with psychiatric disorders. Historically, these nine rulings have had a major impact on the legal rights of patients with psychiatric disorders. A summary of each of these legal decisions is as follows:

1843 – The *M'Naghten rule* first identified a legal defense of not guilty by reason of insanity by stating that persons who do not understand the nature of their actions cannot be held legally responsible for those actions (https://www.law.cornell.edu/wex/m%27naughten_rule).

1965 – In *Griswold v. Connecticut*, The Supreme Court first recognized that a person has the right of marital privacy under the Constitution of the United States (https://www.law.cornell.edu/wex/griswold_v_connecticut_(1965)).

1966 – In *Rouse v. Cameron*, the courts found that a patient committed to an institution must be actively receiving treatment and not merely warehoused (https://casetext.com/case/rouse-v-cameron)

1968 – In *Meier v. Ross General Hospital*, a physician was found liable for the death of a hospitalized patient who committed suicide while under his care. The patient had a previous suicide attempt before the hospital stay. The physician was liable for failing in his *duty to warn* of the threat of suicide in this patient (https://caselaw.findlaw.com/ca-supreme-court/1822578.html)

1972 – In *Wyatt v. Stickney*, the entire mental healthcare system of Alabama was sued for an inadequate treatment program. The court ruled that each institution within the mental healthcare system must (1) stop using patients for hospital labor needs, (2) ensure a humane environment, (3) maintain minimum staffing levels, (4) establish human rights committees, and (5) provide the least restrictive environment possible for the patients (https://mentalillnesspolicy.org/legal/wyatt-stickney-right-treatment.html).

1976 – In the well-known case of *Tarasoff v. The Regents Of the University of California*, the parents of Tatiana Tarasoff sued the university following the 1969 death of their daughter at the hands of Prosenjit Poddar. Poddar had told his therapist that he planned to kill Tarasoff when she returned from summer break. Although the therapist had contacted the police, law enforcement released Poddar because he appeared rational. The court found that the therapist had a *duty to warn of threats of harm to others* and was negligent in not notifying Tarasoff of the threats that had been made against her (https://law.justia.com/cases/california/supreme-court/3d/17/425.html).

1979 – Patients at Boston State Hospital sought the right to refuse treatment in *Rogers v. Okin*. Based on the 1965 decision regarding the right of personal privacy, the court found that the hospital could not force nonviolent patients to take medication against their will. This ruling also included the directive that patients or their guardians must give informed consent before medications could be given (https://pubmed.ncbi.nlm.nih.gov/6134270/ and https://muse.jhu.edu/article/404046).

1983 – In *Rennie v. Klein*, a patient claimed a hospital violated his rights when he was forced to take psychotropic medications. The ruling again addressed the right to refuse treatment and the right to privacy, and it furthered the necessity of obtaining informed consent (https://pubmed.ncbi.nlm.nih.gov/11648483/).

1992 – *Foucha v. Louisiana* demonstrated that the nature of an ongoing psychiatric commitment must *bear some reasonable relation to the purpose for which the patient is committed* (Foucha v. Louisiana, 1992). When Foucha was first hospitalized, the indication was a patient who was considered mentally ill and dangerous. The ruling recognized that patients who are no longer mentally ill do not require hospitalization and that patients are not required to prove themselves to be no longer dangerous (https://www.law.cornell.edu/supct/html/90-5844.ZO.html).

Mental health laws have been created to protect patients with psychiatric disorders and regulate their care. These laws often vary by state. Check the Nurse Practice Act within the respective state of practice to determine state-level regulation.

MENTAL HEALTH AND DEINSTITUTIONALIZATION

The changes in mental healthcare over the years show a shift in care from institutionalization to community settings, also known as deinstitutionalization (Boyd, 2018). Deinstitutionalization was also significant because this shaped our current community and mental health treatment for many vulnerable individuals including the homeless and those with substance use disorders. During the era of state hospitals, mentally ill individuals were less likely to be chronically homeless. While deinstitutionalization was a noble concept, it was not well implemented. The lack of existing public health infrastructure left communities unprepared to manage those with chronic mental illness. Additionally, the arrival of inexpensive and accessible illicit drugs like crack cocaine, changed the face of communities and left those with mental illness even more vulnerable. The lack of affordable treatment for mental health disorders contributes to both individual and public health risk.

Two of the most important concepts in civil rights law are the writ of habeas corpus and the least restrictive alternative doctrine (Halter, 2018). The writ of habeas corpus pertains to holding people against their will. Psychiatric patients are included in this protection and they have the right not to be detained unless individual welfare is involved. Additionally, the least restrictive alternative doctrine states that a patient's autonomy must be upheld whenever possible (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2733575/pdf/behavan00025-0105.pdf). In practice it means that nurses need to try to manage patients' symptoms and behaviors with psychotherapeutic interventions (milieu management, communication, and behavioral approaches) first. If symptoms are not fully or adequately managed, nurses should document what was attempted and ineffective in order to move to more restrictive measures or levels of care (i.e. move up the treatment hierarchy to more restrictive approaches such as medications/chemical restraints, seclusion, and/or physical restraints). Each time a more restrictive measure is applied, documentation needs to support which lesser restrictive strategies were attempted and describe their lack of efficacy.

An understanding of civil rights and state regulations is important to patient care procedures. Admission of psychiatric patients can be voluntary or involuntary, but neither voluntary nor involuntary admission indicates the ability of the patient to make decisions (Halter, 2018). Admission procedures are in place to protect the patient and the public. Involuntary admission is used when patients are a danger to self or others or cannot take care of themselves. However, all patients are to be treated with respect and have the right to informed consent, the right to refuse medications, and the right to the least restrictive treatments (Boyd, 2018). Furthermore, the patient must be seen by a specified number of providers who confirm that the patient meets the criteria for involuntary admission.

THE CONSUMER BILL OF RIGHTS AND CONFIDENTIALITY

In 1997, President Clinton appointed the Advisory Commission on Consumer Protection and Quality in the HealthCare Industry. The Commission, co-chaired by Donna Shalala, secretary of the Department of Health and Human Services at the time, issued its final report, which included a Consumer Bill of Rights & Responsibilities. Of interest to psychiatric nurses is the section on confidentiality of health information. Patients with psychiatric disorders are expressly protected in the confidentiality of their records; practitioners may not share information with any third party without the express written consent of the patient or their legal guardian. The patient can withdraw consent to release information at any time.

CONSUMER BILL OF RIGHTS AND RESPONSIBILITIES

The Commission's consumer bill of rights consists of the following rights and responsibilities:

1. Access to Accurate, Easily Understood Information about health plans, facilities, and professionals to assist consumers in making informed health care decisions;
2. Choice of Health Care Providers that is sufficient to ensure access to appropriate high quality care. This right includes providing consumers with complex or serious medical conditions access to specialists, giving women access to qualified providers to cover routine women's health services, and ensuring continuity of care for consumers who are undergoing a course of treatment for a chronic or disabling condition;
3. Access to Emergency Services when and where the need arises. This provision requires health plans to cover these services in situations where a prudent layperson could reasonably expect that the absence of care could place their health in serious jeopardy;
4. Participation in Treatment Decisions including requiring providers to disclose any incentives -- financial or otherwise -- that might influence their decisions, and prohibiting gag clauses that restrict health care providers' ability to communicate with and advise patients about medically necessary options;
5. Assurance that Patients are Respected and Not Discriminated Against, including prohibiting discrimination in the delivery of health care services based on race, gender, ethnicity, mental or physical disability, and sexual orientation;
6. Confidentiality provisions that ensure that individually identifiable medical information is not disseminated and that provide consumers the right to review, copy, and request amendments to their medical records;
7. Grievance and Appeals Processes for consumers to resolve their differences with their health plans and health care providers -- including an internal and external appeals process; and
8. Consumer Responsibilities provisions that ask consumers to take responsibility by maximizing healthy habits, becoming involved in health care decisions, carrying out agreed-upon treatment plans, and reporting fraud.

Note. Adapted from the President's Advisory Commission. (1997). Consumer bill of rights and responsibilities. Retrieved from https://govinfo.library.unt.edu/hcquality/press/cborimp.html

In addition to the Consumer Bill of Rights, the Health Insurance Portability and Accountability Act (HIPAA) was enacted in 1996 and went into effect in 2003 (U.S. Department of Health and Human Services, 1996). This act was designed to protect patient health information more securely and has been a major force behind the use of electronic health records.

There are a few circumstances where confidentiality may be waived in mental health (U.S. Department of Health and Human Services, 2000). If the patient has made a direct threat against another person, the healthcare provider has a clear duty to warn the endangered individual (U.S. Department of Health and Human Services, 2000). If the patient has reported actual or suspected abuse (including molestation) or neglect of a minor child, the healthcare provider has an obligation to report this to the appropriate Child Protective Services division of the state's Office of Family and Children. A judge may also order documents (clinical records) to be turned over to the court for examination. A subpoena to appear in court does not constitute a judge's order to release information; it merely mandates the appearance of the subpoenaed individual. Violation of the confidentiality of a patient with a psychiatric illness in situations other than those outlined by law may subject the nurse to legal action and revocation of licensure. Most agencies have an acceptable form that identifies to whom information can be released, the date that the release is valid, and types of information that can be shared.

NURSING LIABILITY IN MENTAL HEALTH

The state nurse practice act (NPA) is the single most important piece of legislation for the nurse because it affects ALL facets of nursing practice. Each state has its own NPA for which the courts have jurisdiction. NPA's generally grant specific provisions on how nurses practice in a state and define 3 levels of nurses: LPNs, RNs, and APRNs with defined scopes of practice. The nurse practice act also established a state board of nursing. Its main purpose is to ensure enforcement of the act and protect the public.

Individuals who present themselves as nurses must be licensed. The National Council of State Boards of Nursing serves as a clearinghouse, further ensuring that nursing licenses are recorded and enforced in all states. Individual state boards of nursing develop and implement rules and regulations regarding the discipline of nursing. Most changes deal with modifications with rules and regulations rather than the act itself. Nurses must be advised of the provisions of the state's nurse practice act. Thus, what is acceptable in one state is not necessarily acceptable in another state.

The nurse has legal liability in the psychiatric setting when caring for patients (Boyd, 2018). *Torts* are wrongful acts that result in injury, loss, or damage and can be intentional or unintentional (Boyd, 2018). *Intentional torts* are voluntary acts that result in harm to the patient and include the following:

- *Assault* involves any action that causes an individual to fear being touched in any way without consent. Examples of this include making threats to restrain a patient or making threats to administer an injection for failure to cooperate.
- *Battery* involves harmful or unwarranted contact with a patient; actual injury may or may not occur. Examples of this include touching a patient without consent or unnecessarily restraining a patient.
- *False imprisonment* involves the unjustifiable detention of a patient. Examples of this include inappropriate use of a restraint or inappropriate use of seclusion

Unintentional torts are involuntary acts that result in harm to the patient and include the following:

- *Negligence* involves causing harm by failing to do what a reasonable and prudent person would do in a similar circumstance (anyone can be negligent). Examples of this include failing to erect a fence around a pool and a small child drowns or leaving a shovel on the icy ground and someone falls down on it and cuts their head.
- *Malpractice* is a type of negligence that refers specifically to healthcare professionals. An example of this includes a nurse who does not check the treatment orders and subsequently gives a medication that kills the patient.

CULTURAL CONSIDERATIONS IN MENTAL HEALTHCARE

Culture influences various aspects of mental health, including the recognition and expression of psychiatric symptoms, coping styles, community support, and the willingness to seek treatment. Cultural concepts of distress are recurrent, locality-specific patterns of aberrant behavior that are not linked to a specific diagnostic category in the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (American Psychiatric Association, 2013). More impoverished communities have environmental risks such as a lack of access to healthy nutritious foods, clean soil, and clean air in urban areas. This may impact mental health via physiological/neurological impact and deficits, especially in vulnerable populations.

As of 2021, the percentage of the US population that self-identified as African American had grown to 13.4% (U.S. Census Bureau QuickFacts: United States). Although anyone can develop a mental health problem, African Americans may experience barriers to appropriate mental healthcare(National Alliance on Mental Illness, n.d.a). For example, the poverty rate among African Americans in 2020 was 19.4%, with 11.4 million people of all races living in poverty (Income and Poverty in the United States: 2020 [census.gov]). Poverty directly relates to mental healthcare access. The poverty rates in the African American community combined with provider bias and patient distrust of the health system can result in subpar mental health care for African Americans (NAMI: National Alliance on Mental Illness. In addition, the African American community has experienced increasing diversity because of immigration from Africa, the Caribbean, and Latin America. Mental healthcare providers need to understand this diversity and develop cultural competence (Boyd, 2018). Contributing to this cultural consideration is the estimation that over half of the prison population has a mental illness and that African Americans are five times more likely to be incarcerated than Whites (Mental Health America, n.d.; Sakala, 2014).

The Latin/Hispanic American population is rapidly growing, currently comprising 18.6% of the nation's total population (U.S. Census Bureau QuickFacts: United States). In 2020, 17.0% of Latin/Hispanic Americans were living in poverty. Rates of mental health disorders in this population are similar to those of non-Hispanic Caucasians, with some exceptions:

- Older Hispanic adults and Hispanic youths are more vulnerable to the stress associated with immigration and acculturation' and experience more anxiety, depression, and drug use than non-Hispanic youths.
- Depression in older Hispanic adults is closely correlated with physical illness; and suicide rates were about 50% that of non-Hispanic Whites, although suicide ideation and unsuccessful attempts were higher (State of Mental Health in America - 2020_0.pdf (mhanational.org).
- There is a higher incidence of post-traumatic stress disorder (PTSD) in Hispanic men, some of which may be attributable to social disorder experienced before immigration. As of 2020, there were 1.2 million Hispanic or Latinos who are US military veterans (U.S. Census Bureau QuickFacts: United States).
- The rates of substance use disorders are slightly lower in Hispanic women and slightly higher in Hispanic men. Hispanics are approximately twice as likely as Whites to die from liver disease, which could be associated with substance use (Hispanic Health | VitalSigns | CDC).

There are few Hispanic children in the child welfare system, but Hispanics are twice as likely as Whites to be incarcerated at some point in their lifetime (Sakala, 2014). The lack of Spanish-speaking mental healthcare providers has been a problem, likely causing fewer than 1 in 11 Hispanic individuals with a psychiatric disorder to seek treatment (Mental and Behavioral Health - Hispanics - The Office of Minority Health (hhs.gov)). Misdiagnosis is common and is often related to language barriers. Among Hispanics living in the United States, one in three do not speak English well (Hispanic Health | VitalSigns | CDC). Hispanic Americans are more likely to use folk remedies solely or as a complement to traditional care, and some may consult church leaders or healers for more traditional care (Hispanic/Latinx | NAMI: National Alliance on Mental Illness).

Asian Americans and Pacific Islanders comprise just over 20 million of the US population and are considered one of the fastest growing racial/ethnic groups within the United States (U.S. Census Bureau, 2020; Wyatt, Ung, Park, Kwon, & Trinh-Shevrin, 2015). By 2060, it is projected that 1 in 10 children in the United States will be Asian (Wyatt et al., 2015). There are numerous ethnic subgroups included in the Asian American/Pacific Islander demographic, with over 100 languages and dialects (Asian American/Pacific Islander Communities and Mental Health | Mental Health America (mhanational.org)). Thirty-two percent of Asian Americans have difficulty accessing mental healthcare services because they do not speak fluent English (Asian American/Pacific Islander Communities and Mental Health | Mental Health America (mhanational.org)). For example, older Asian Americans may not understand questions or the intent of a medical interview, and they may give affirmative answers to avoid confrontation. Asian Americans and Pacific Islanders are the least likely of any group to seek help with mental health issues (Hernandez, Nesman, Mowery, Acevedo-Polakovich, & Callejas, 2015). Although fewer mental health concerns are reported in this group, few epidemiological studies have included this population (Asian American/Pacific Islander Communities and Mental Health | Mental Health America (mhanational.org)). Asian Americans tend to exhibit somatic (physical) symptoms of depression more frequently than emotional symptoms (Boyd, 2018; Kalibatseva & Leong, 2011). The focus on physical symptoms and misdiagnosis serves as a barrier to mental healthcare for this population. Suicide rates within this population should be monitored closely by examining risk factors such as acculturation, family discrimination, social acculturalization, and discrimination (Boyd, 2018; Wyatt et al., 2015).

NURSING CARE IN MENTAL HEALTH

Standards of practice

The American Nurses Association's scope and standards of practice of psychiatric-mental health nursing *(Psychiatric-Mental Health Nursing Scope and Standards of Practice)* provides the foundation for the application of the nursing process to patients with psychiatric disorders (American Nurses Association, 2014). The *PMHNP Scope and Standards of Practice* also serves as a reference document for the National Council Nursing Licensure Examination (NCLEX) and many state nurse practice acts. The *PMHNP Scope and Standards of Practice* includes each step of the nursing process: assessment, diagnosis, planning, implementation, and evaluation.

When using the *PMHNP Scope and Standards of Practice*, the nurse should consider the individual's age, language, and culture. The nurse should also address each patient's developmental level. Note that the age and the developmental level may be incongruent in certain mental illnesses. Use age-appropriate communication techniques to establish a therapeutic alliance with both the patient and the family. Additionally, observations of behaviors and reactions are just as important as the conversation. Parents are often present during a child assessment. However, if abuse or neglect is suspected, it may be prudent to talk to the child or adolescent alone. In cases involving child sexual abuse or other uncomfortable issues, the nurse may need the assistance of a healthcare provider with advanced training to interview the child.

When working with adolescents, the therapeutic alliance may be hindered by concerns of confidentiality. Reassure the adolescent that conversations are confidential, and information is only

shared with team members, except in certain circumstances. In cases of suicidal or homicidal thoughts, sexual abuse, or other high-risk behaviors, the nurse must share the assessment information with other healthcare professionals and the parents. In fact, identifying risk factors in this age group is an important aspect of the assessment.

THE NURSING PROCESS IN MENTAL HEALTH

The physiological health exam and work-up is an initial step for thoroughly and accurately diagnosing and managing mental health conditions, including common screening labs and physical exams to rule out common medical issues that could be causing, mimicking, or contributing to mental health symptoms. Some physiological conditions present with psychiatric symptoms. Ensuring that the patient has a baseline physical assessment assist in the accurate diagnosis and appropriate treatment of all conditions, thus demonstrating the mind-body connection. Because of this link, the history and presenting symptoms of the patient are of utmost importance.

The nursing process is a systematic way of developing an individualized plan of care for those experiencing a disruption in mental health status. The traditional nursing process consists of performing a comprehensive assessment, formulating nursing diagnoses, developing a care plan, implementing selected nursing interventions, and evaluating the outcome or effectiveness of those interventions (Boyd, 2018). Most facilities have their own documentation that follows accepted guidelines for mental health assessment.

Assessment

Creating a therapeutic alliance is an important step in the holistic care of the patient. This connection provides an optimal setting for obtaining the psychosocial and psychiatric history. The first step is to obtain a thorough history of the patient, incorporating elements of current and past health problems, social issues affecting health, and cultural or spiritual beliefs that may support or interfere with prescribed healthcare treatments (Halter, 2018). The nurse should obtain the history in an environment conducive to effective communication between the nurse and the patient. Family members and significant others may or may not be present, or they may be present for a portion of the time and then be asked to step out to maintain the patient's confidentiality. Interviews should be conducted in a private conference room or patient's room (if inpatient or residential) rather than in a public area where others may overhear. If personal safety is a concern, the nurse may request another staff member to be present. The nurse should remove distracting elements such as a television or radio. If the nurse determines that the patient is too ill to be able to provide accurate information or that the interview process itself will be detrimental to the patient's health, then the nurse should obtain information from other reliable sources, such as family members, social workers, therapists, and primary healthcare providers (Boyd, 2018). Documentation of the source of information is important, particularly when the patient is unable to provide an accurate history. Although the psychiatric nurse may gather information from other sources, it is important that the nurse not disclose any information regarding the patient's status without the patient's written consent to avoid a breach in confidentiality.

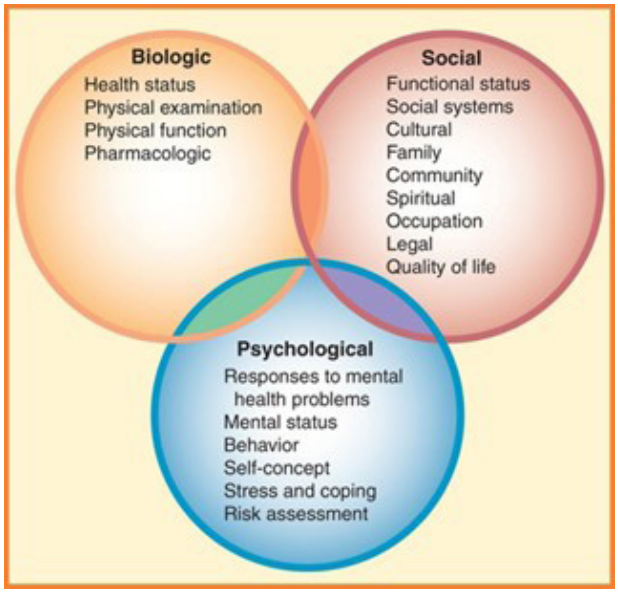
Nursing diagnosis and planning

Most healthcare facilities have an existing form to guide the nurse in data collection. The data collection process assists the nurse in developing a nursing diagnosis list. After identifying real and potential problems, the nurse develops written nursing diagnoses to address each problem. Nursing diagnoses are important in structuring appropriate, efficient nursing care while serving as a common language nursing team members. Prioritization is also based on Maslow's Hierarchy of needs so that physiological and safety needs that are outlined in nursing diagnoses will be addressed first. The nursing diagnosis drives the planning process in the care of patients with psychiatric-mental health disorders. Implementation of interventions is driven by goals established during the planning process. Short- and long-term goals must be observable, measurable (i.e., goals or outcomes that can be evaluated) and realistically attainable in the given time frame and setting. Identifying contributing factors and behavioral symptoms can directly lead to the development of short- and long-term goals that help evaluate progress. Interventions for this population will always include therapeutic communication and the mental status examination (Boyd, 2018).

The biopsychosocial framework

The biopsychosocial framework is a well-accepted, holistic model for organizing healthcare issues (Boyd, 2018). Three interdependent domains have separate treatment focus but interact to provide a framework for implementing nursing care through a systematic process.

The *biologic domain* is related to functional health patterns in mental health such as sleep, exercise, and nutrition. Pharmacologic principles in medication administration are related to neurobiological theories. The *psychological domain* contains the interpersonal dynamics that influence emotions, cognition, and behavior. This generates theories and research critical in understanding symptoms and responses in mental disorders. Therapeutic communication techniques exist in this domain, as there are many cognitive and behavioral approaches in patient care. The *social domain* accounts for the family and community influences in mental disorders. While these influences do not cause mental illness, manifestations and disorders are significantly affected by these factors.



Boyd, 2018

A comprehensive nursing assessment enables the nurse to make sound clinical judgments and plan appropriate interventions. Assessment skills in psychiatric nursing are essential in-patient care. Although data collection and assessment vary among clinical agencies, the psychiatric examination consists of two parts: the psychiatric history and the mental status exam. Patients are often reluctant to discuss mental illness because of the associated stigma. Clinical reasoning in nursing practice depends on critical thinking skills such as problem solving and decision making, where nurses must analyze, interpret, and evaluate biopsychosocial data in the context of the nursing process.

THE MENTAL STATUS EXAMINATION

The mental status examination is a structured means of evaluating the psychological, physical, and emotional state of a patient with a psychiatric disorder to facilitate appropriate healthcare treatments. The nurse may also identify significant problem areas to be addressed in the treatment plan. Mental status exams are an essential tool for evaluating the safety of the patient and caregivers. Although each healthcare facility may vary slightly in its approach, all mental status exams include the same basic elements. These include an assessment of the patient's appearance, behaviors, thoughts, and moods. These are called the ABC's of MSE: (1) A-appearance, (2) B- Behavior and (3) C- Cognition which includes mood, affect and speech. Speech is a reflection of cognition (https://psychscenehub.com/psychinsights/ten-point-guide-to-mental-state-examination-mse-in-psychiatry; Boyd, 2018).

Appearance

Appearance includes primarily objective data based on observations of the patient's general appearance. The nurse assesses the patient's overall hygiene and grooming, considering gender, apparent age, height/weight, dress, odors, and tattoos/piercings. Height and weight should be documented along with nutritional status. The nurse evaluates if the patient looks the stated age since chronological age may not be a reflection of the client's physical/mental status. For example, a patient appears in their 50s, but the actual age is 35, suggesting poor self-care or illnesses (Boyd, 2018).

Behavior

The patient's behavior should be noted during the interview. Consider any mannerisms, notable movements such as agitation, physical slowing (retarded movements), tics, or other abnormal movements. It is important for the nurse to be developmentally and culturally aware during the mental status examination. For example, American culture considers eye contact to be a sign of respect and attention, but other cultures deem eye contact as offensive, challenging, or arrogant (Boyd, 2018).

Mood and affect

Mood is subjective (whatever the patient states) so this must be asked directly (e.g., How is your mood?) and is typically documented in quotations (Mood is "happy"). Affect is objective data (the nurse's observations) based on clinical descriptors that take into account the tone, range, and quality, together with facial expressions and body language that reveal the emotional state or feelings of the person. Mood and affect do not necessarily have to be consistent or similar. For example, a patient may state that their mood is "fine" but through their presentation they are expressing significant difficulty in their emotions with anger, sadness, or depression. Affect is the facial expression, body language, voice, or tone that reveals the emotional state or feelings of a person (Boyd, 2018).

A *dysphoric mood* indicates that the patient is persistently depressed, lethargic, apathetic, or "down" and is usually accompanied by a depressed affect. However, the affect may also be described as anxious or flat, meaning that there is no facial expression of feelings. A *euphoric mood* is an elevated emotional state that may be associated with an affect that is giddy, cheerful, or excessively bright. A *labile affect* is one that is rapidly changing and unpredictable – the patient may be cheerful, then suddenly become enraged with little provocation or may burst into tears unexpectedly. A labile affect can accompany various psychiatric disease states such as depression or psychosis. Substance use can also affect the patient's mood in many ways, depending on the degree of intoxication, the substance used, and any withdrawal symptoms. Some medications can interfere with the physical expression of an emotion, resulting in a flat or blunted affect (Boyd, 2018).

Thought processes

Thought processes refer to the way thoughts are organized and structured. One can think of thought process as HOW one is thinking and thought content as WHAT they are thinking. Speech assessment reveals both. Normally, thoughts are logical, sequential, and easily understood by others (in the absence of a known speech or communication disorder). Patients with disorganized thoughts may respond to questions with nonsensical speech because speech often reflects the thought process. There may be difficulty in performing simple activities such as bathing or eating without assistance, even in the absence of a physical impairment. Patients may mix up or confuse medications when a structured system (such as a weekly pill dispenser) is not available. Thoughts can be rapid, racing, or slowed. Poverty of speech can occur where questions are answered with one or two words and patients may be unable to expand on responses or use their imagination. Thoughts can be either abstract or concrete (Boyd, 2018).

A patient's thought processes may also show flight of ideas, as in the following example: "I came here in an ambulance. I wish I had more money! Did you see that TV show about Pekingese dogs the other night?" When a patient is experiencing a flight of ideas, speech is often accelerated and thoughts are random, abruptly changing with little association between thoughts (Boyd, 2018). When assessing a patient's thought processes, the nurse might also note the phenomenon of word salad. In a word salad, the patient's statements have no logical connections, and the thoughts are jumbled – for example: "I don't. Here, he said. My house. Mouse. Spouse." The previous statement also serves as an example of clang association, which is a pattern of using words because they have similar sounds and not because of the actual meanings of the words. A patient may use neologisms or words that don't exist in the English language. Words such as "frugelzip" or "rappeliciosity" will have a meaning that is clear only to the patient.

Thought content

Thought content refers to what the patient is thinking about. Initially, it is helpful to assess preoccupations or obsessions about real-life events, such as finances, employment, or relationships (Boyd, 2018). Sometimes a patient can experience intrusive or ruminating thoughts. An intrusive thought is an unwelcome idea that occurs without conscious effort, and ruminative thoughts

are thoughts that seem *stuck* in the patient's mind. An obsessive patient may have ruminative thoughts that may be unusual, such as a desire to check the door repeatedly to ensure it is locked or the belief that germs may be everywhere. Obsessive thoughts will often lead to compulsive behaviors – such as ritualized handwashing – in part as an attempt to relieve intrusive thoughts and their accompanying anxiety. The nurse's role is to help the patient understand that these thought processes are irrational.

Thought content problems are of essential importance. *Hallucinations* are false sensory perceptions (Boyd, 2018). Auditory, visual, olfactory, gustatory, or tactile symptoms may be present. Auditory hallucinations, such as hearing voices, are the most common in psychiatric disorders (Boyd, 2018). Visual hallucinations are false visual perceptions, such as seeing people who are not present. Patients can also experience a tactile hallucination, known as a false perception of touch (Boyd, 2018). Tactile hallucinations can present as "hands touching me" or "bugs crawling on me" and can exist with psychological or medical conditions such as withdrawal. When caring for a patient experiencing hallucinations, it is important to remember that the brain perceives the reported sensation, meaning that to the patient, it is very real. It is important for the nurse to address hallucinations with the patient; however, nursing judgment on how to therapeutically address them is critical. Initially, pointing out that the hallucination does not exist may jeopardize the development of a secure nurse-patient relationship; however, rationalizing with and helping the patient reason are important elements in the progression of treatment.

Delusions are fixed false beliefs (Boyd, 2018). The patient experiencing a delusion is certain that something is true, even when there is no substantiating evidence to prove the belief. Paranoid patients may be frightened as they often believe they are being watched, monitored, or spied upon by others. These individuals may report cars following them or mysterious phone calls late at night. Occasionally, a patient with paranoia may fear being poisoned and refuse medications or food. Religious delusions can also occur where the patient may feel persecuted by demons or may be very excited about a special relationship with God or with angels. Careful assessment by the healthcare provider is important to determine a patient's baseline religious beliefs so as not to label a thought as delusional when it is a well-accepted belief for the patient. Somatic delusions are uncomfortable beliefs that there is something wrong with one's body (Boyd, 2018). For example, some patients may believe that their bowels are necrotic or dead or may believe that their brain is missing.

Other delusions may exist such as a belief that aliens are broadcasting signals, or a belief that loved ones have been replaced by clones. It is always essential to determine what feelings are elicited in the patient because of the delusional thoughts. Paranoid thoughts will drive fear and fight-or-flight responses. The patient may set up protective traps around the home to prevent others from entering. Religious delusions may be pleasant and make the patient feel special, or they may be so persecutory that the patient becomes depressed and suicidal. Somatic delusions can lead to excess visits to healthcare providers and may result in the label of "hypochondriac" for the patient.

Ideas of reference can also occur in which the patient may believe that all events in the environment are related to or about them (Boyd, 2018). Patients experiencing ideas of reference may believe that, when in a group setting, others are talking about or ridiculing them (Boyd, 2018). Sometimes, ideas of reference are associated with grandiosity, or the belief that one is especially important or powerful (Boyd, 2018). An elderly homemaker who suddenly believes herself to be the next Marilyn Monroe may be experiencing grandiosity. Grandiose patients attempt to convince others of their importance and may present with perceived rude or arrogant behavior patterns.

Cognition and memory

Cognitive abilities are the elements of thinking that determine attention, concentration, perception, reasoning, intellect, and memory (Boyd, 2018). Attention span is particularly important in evaluating the mental status because a decreased attention span often limits comprehension. Decreased concentration levels and distractibility may occur in patients with disorders that affect attention, as well as for those with depression and other mental health concerns.

The nurse can assess the patient's perception by asking open-ended questions that encourage description, such as "What makes you feel anxious?" (Boyd, 2018). Intellect is assessed through clinical assessment as well as intelligence testing (American Psychiatric Association, 2020). Intelligence quotients (IQs), as well as cognitive, social, and psychomotor capabilities, are assessed to determine intellectual function. Intellectual disabilities are categorized as mild, moderate, severe, or profound. Although IQ scores can serve as a parameter for these categories, the level of severity is determined by adaptive functioning (American Psychiatric Association, 2020).

An assessment of memory consists of three basic parts: immediate recall, recent memory, and remote memory (Boyd, 2018). A simple test of recall is to give the patient three items to remember and then 5 minutes later ask the patient to state those items. *Immediate recall* can be quickly determined by asking what a patient consumed for breakfast. *Recent memory* is recall of one to several days. Questions regarding family members' names or place of residence help assess recent memory. *Remote memory* is recalled from several days to a lifetime. Asking patients where they grew up, what their parents' names were, or where they went to school readily provides this information.

Memory assessments help in differentiating a thought disorder from a dementia disorder. Patients with a primary psychiatric disturbance may be delusional in their beliefs but extremely accurate in memory and recital of facts and dates. A patient with early dementia may lose some short-term memory first, progressing to the loss of immediate recall, then finally to long-term memory loss (Boyd, 2018). *Orientation* means that patients are aware of who they are (person), where they are now (place), the approximate time and date (time), and awareness of the circumstances (situation). A disoriented person may be suffering from a cognitive disorder, drug or alcohol use or withdrawal, or several physical or psychological health problems.

Insight and motivation

Insight refers to patients that demonstrate understanding of their illness and the steps necessary to treat or manage the illness. The determination of a patient's level of insight is often associated with treatment adherence. The goal is that understanding leads to adherence. Occasionally, nurses encounter patients who demonstrate good insight and knowledge, but continue to display nonadherence to recommended treatments. Nurses should ask these patients about barriers to treatment, such as financial constraints or concerns regarding health insurance. The stigma of having a psychiatric diagnosis may lead the patient to feel ashamed or angry. Anger may be causing the patient to intentionally deny and refuse adequate treatment. Hidden motivations, such as the defense mechanisms may also have a significant impact on the patient.

Judgment

Healthcare choices can reflect *judgment*. This can be a positive or negative reflection on an ability to reach a logical decision about a situation (Boyd, 2018). For example, the patient with diabetes who continues to consume a diet high in sugar is demonstrating poor judgment. Actions and behaviors are often signs of judgment capabilities. A manic patient may spend their life savings on a trip or a lottery ticket. However, once in the normal or melancholic state, the patient may have no memory of the incident. Proper evaluation of the mood state when the actions were carried out is an important part of the assessment. Conversely, the patient who recognizes that an increase in paranoia is a sign of decompensation and seeks out emergency treatment is demonstrating good judgment. A patient's insight, or awareness of their own feelings, relates to the ability to display logical judgment (Boyd, 2018). Assessing and understanding a patient's ability to make positive or negative choices is an important piece of planning effective mental healthcare.

Safety

Finally, an evaluation of safety is important in any mental status assessment. The essential areas to examine include safety of self and safety of others. The nurse should determine if the patient has thoughts or urges of intentional harm. When suicidal thoughts are noted, inpatient treatment must be considered. Assessing suicide risk consists of asking the patient about a suicide plan, suicidal intent, and the available means to harm oneself. A well-developed suicide plan with means at hand may necessitate forcing an involuntary hospital stay, whereas an impulsive episode of self-mutilating may be best treated by an intensive outpatient program with family supervision. For example, a hunter who thinks about shooting himself is at much higher risk than the office worker who doesn't own or have access to a gun. Determining the lethality of the means available is also essential.

Patients experiencing extreme emotional pain may also self-mutilate by cutting or burning their arms, legs, or other areas. Although this is not considered suicidal behavior, it is high-risk behavior that indicates significant emotional distress.

The nurse should also determine the degree of risk of harm to others. There are two distinct areas in which patients with a psychiatric disorder may lose their rights to confidentiality: a threat to harm or kill another person and the report of child or elder abuse (Halter, 2018; U.S Department of Health and Human Services, 2019). *Duty to warn is an obligation to warn third parties when they may be in danger from a patient* (Halter, 2018, p. 99; Duty to Warn). The nurse must use all means necessary to reasonably contact the individual at risk, including notifying the police. In most healthcare settings, there are policies to ensure the report is made accurately and documented appropriately. Across the United States, nurses are considered mandatory reporting agents when a patient offers knowledge of abuse, molestation, or neglect of vulnerable patients. The nurse is obligated to report this to the local Child Protective Services agency (Duty to Warn). However, there is a conflict between state and federal law when child abuse is revealed during drug and/or alcohol treatment, and a court order is required for disclosure (Halter, 2018). State laws vary and healthcare providers should be very clear on their respective state laws and facility policy in terms of confidentiality.

THE THERAPEUTIC RELATIONSHIP

Hildegard Peplau applied Sullivan's teaching to her own theory, which nurses still use today in practice. Peplau viewed the nurse-patient relationship as representative of the patient's relationship with other important people in their life (husband, wife, mother, father, etc.). By analyzing the dynamic between the self and the patient, the nurse draws inferences about how the patient interacts with others and helps the patient to develop insight into these behaviors to promote change. Furthermore, Peplau applied Sullivan's views on anxiety as a driving force behind behaviors and related these views to nursing practice and a patient's ability to perceive and learn. For example, mild anxiety promotes learning, whereas severe or panic levels of anxiety prevent learning and distort perceptions (Keltner, 2014, p. 87).

From her own research, Peplau developed the therapeutic model of the nurse-patient relationship and introduced this in 1952 in her book entitled *Interpersonal Relations in Nursing: A Conceptual Frame of Reference for Psychodynamic Nursing*. Today, this framework is relevant as a basis of nurse-patient relationships. The nurse performs several roles while engaged in the relationship, including advocate, teacher, role model, and healer. Peplau saw these roles as significant in each phase of the nurse-patient relationship, all of which overlap and work together to facilitate interventions. There are traditionally three phases in the therapeutic relationship: the initiation (orientation) phase, the working phase, and the termination phase (Edberg, Nordmark, & Hallberg, 1995). Peplau (1952) identified five phases: orientation, identification, exploitation, resolution, and termination.

In the orientation phase, the nurse establishes rapport and begins to discuss the parameters of the relationship. The nurse also collaborates with the patient to identify the problem and extent of intervention needed, and how the patient and the nurse will work together to find solutions (Jones & Bartlett Learning, n.d.). Here the nurse can discuss confidentiality while developing the plan of care. The nurse will also address termination of the relationship. This involves informing the patient that the interactions will take place over a specific period. This helps the patient plan for the termination phase so that complications are less likely to arise when the nurse-patient relationship ends. An example of an orientation-phase introduction is:

> *Good morning, Mr. Jamison. I am Chris and I will be your nurse while you are a patient. I would like to arrange a time to meet this morning to discuss how we will work together to develop the plan of care for the next week. Together we will develop strategies to manage your depression and we will continue to meet daily to evaluate what you have accomplished before you are discharged.*

In the working phase, identification, exploitation, and resolution take place. During identification, the patient begins to identify with the nurse independently, dependently, or interdependently (Jones & Bartlett Learning, n.d.). It is during identification that the nurse reinforces the understanding of the meaning of the patient's situation (Jones & Bartlett Learning, n.d.). During exploitation, the patient utilizes the nurse's services based on personal needs, and once needs are resolved during resolution, mature goals emerge (Jones & Bartlett Learning, n.d.). During this working phase, the patient can practice new techniques or behaviors to manage thoughts, feelings, and behaviors that have contributed to their symptoms and created problems in relationships, occupational functioning, or interpersonal well-being. These skills and strategies can be practiced within the safety of the inpatient, partial hospital, or outpatient environment. The nurse helps to promote problem-solving skills, self-esteem, and behavioral changes. Unconscious thoughts and behaviors may arise in the working phase. It is important to address lingering or past issues to aid in the resolution of present symptoms. The patient learns about *self*, develops coping mechanisms, and tests new behaviors. During this phase, transference and countertransference often occur. Transference takes place when the patient unconsciously displaces feelings for another onto the nurse (Boyd, 2018). Likewise,

countertransference can occur when the nurse's emotions may also be displaced onto the patient (Boyd, 2018). The nurse's self-awareness and ability to maintain healthy boundaries and remain patient focused are important elements of the nurse-patient relationship.

The termination phase is the final phase of the relationship. In this phase, the nurse and the patient discuss the goals and outcomes achieved, review coping skills, and determine how to incorporate new behaviors into life outside of the facility. Closure of the relationship occurs so that the patient and the nurse can move forward. However, this phase can elicit strong emotions of loss or abandonment. For the nurse, feelings of guilt can arise if the patient has not met all goals. It is not appropriate for the nurse to meet with the patient once discharged. The nurse can plan for discharge by recalling successes achieved with the patient and taking pride in helping the patient gain positive outcomes to date. The patient may experience feelings of abandonment which may be revealed in behavior or emotions. For example, the patient may avoid signing necessary papers or have sudden outbursts. The nurse may need to discuss the importance of the termination phase with the patient, help redirect the patient to reflect on successes achieved while working together, and refer the patient to the next level of care, if appropriate (https://psychscenehub.com/psychinsights/ten-point-guide-to-mental-state-examination-mse-in-psychiatry/).

THERAPEUTIC COMMUNICATION

Therapeutic communication and the therapeutic relationship are a significant part of mental health nursing. Hildegard Peplau reiterated this sentiment in her work many times, stating that understanding was central to the nurse-patient relationship (Ramesh, 2013). Therapeutic communication differs from social communication in that patient goals are the central focus of the interaction. The goal may be to solve a problem, examine self-defeating behaviors, or promote self-care. Additionally, therapeutic communication involves active listening and responding in a way that creates rapport and moves the patient toward the end goal.

Therapeutic communication involves trust, boundaries, empathy, genuineness, and respect for the patient, regardless of the patient's condition (Halter, 2018; Morgan & Townsend, 2019). Sometimes, recognizing an individual's behaviors and making statements can add to the assessment data and provide insight into the patient's current state. An example is "I notice you are pacing more today." Allow the patient to respond. Remember that no response from an individual provides further insight into the individual's state of mind.

One important aspect of therapeutic communication is the therapeutic use of self. This is when the nurse uses self-disclosure in a goal-oriented manner to promote trust and teach the patient how to view the feelings or actions of others (Riley, 2015). Use of self, however, should not reveal personal details. Effective use of self involves self-reflection, self-awareness, and self-knowledge. As in any nurse-patient interaction, it is important to remain objective and nonjudgmental while considering the patient's needs. Nonverbal communication can tell the nurse a lot about the patient. Awareness of how the patient gestures or moves while conversing is vital in determining verbal/nonverbal congruence. Sitting across from the patient with an open stance demonstrates openness and a willingness to listen. An angled position or sitting side by side can promote comfort. Additionally, the doorway should never be blocked; this promotes safety as well as prevents the patient from feeling trapped or confined (Boyd, 2018).

A general opening, such as asking how the patient slept, can help facilitate the conversation. Gradually start asking open-ended questions to encourage the patient to engage, such as "Tell me a little about what has been going on." If anxiety or nervousness is observed, the nurse may need to step back and alter the questions or provide encouraging statements such as *go on* or *tell me more about that*. Those types of statements confirm that the nurse is listening and is open to knowing more about the topic. *Why* questions can be perceived as challenging and judgmental (e.g., "Why would you do that?"). Reword the question so that the patient can answer without feeling belittled or betrayed. It is important to get as much of the patient's history as possible. However, this may be difficult if the patient has severe symptoms that may limit their ability to carry on a conversation. In that case, observation will take precedence in the interview.

Samples of therapeutic and nontherapeutic communication techniques are provided in Table 1. *Therapeutic and nontherapeutic communication techniques.* Each of these techniques will elicit responses that give the nurse insight into the patient's thoughts and emotions (Boyd, 2018). Use open-ended questions so that the patient can respond with more than a yes or no answer. Give the patient enough time to answer the question as well. Avoid using jargon or medical terminology (https://publichealth.tulane.edu/blog/communication-in-healthcare/).

Table 1. Therapeutic And Nontherapeutic Communication Techniques

Therapeutic	**Example**
Open-ended question	"How are you feeling?"
Offering self	"I'll sit here with you for a while."
Giving general leads	"Go on … you were saying."
Silence	Sitting quietly.
Active listening	Leaning forward, making eye contact, and being attentive.
Restating	"So, what you're saying is …"
Clarification	"I don't quite understand. Could you explain …"
Making observations	"I notice that you shake when you say that."
Reflecting feelings	"You seem sad."
Encouraging comparisons	"How did you handle this situation before?"
Interpreting	"It sounds like what you mean is …"
Nontherapeutic	**Example**
Closed-ended question	"Did you do this?"
Challenging	"Just what do you mean by that, huh?"
Arguing	"No. That's not true."
Not listening	Body turned away, poor eye contact.
Changing the subject	(Patient states he is sad.) "Where do you work?"
Being superficial	"I'm sure things will turn out just fine!"
Being sarcastic	"Well, that's not important or anything. Not!"
Using clichés	"All's well that ends well."
Being flippant	"I wouldn't worry about it."
Showing disapproval	"That was a bad thing to do."
Ignoring the patient	"Did anyone see the news today?"
Making false promises	"I'll make the doctor listen to you!"

(Boyd, 2018)

During the evaluative process, the nurse will assess the use of defense mechanisms that may indicate the need for ongoing revision of the plan of care. Consistent evaluation of goals and progress is integral for successful nursing care of the patient with a psychiatric-mental health disorder. Sigmund Freud, the grandfather of psychotherapy, believed that most psychiatric disturbances arise out of childhood experiences and the way human beings respond to their environment, and are based on unconscious drives or motivations (Halter, 2018). Freudian therapy, developed in 1936 and referred to as psychoanalysis, attempts to bring the unconscious into consciousness to allow individuals to work through past issues and develop insight into present behaviors. Although classic psychoanalysis as developed by Freud is rarely used today, Freud's understanding of anxiety as well as the unconscious mind are significant drivers in understanding the human response with defense mechanisms (Halter, 2018).

Any behavior or psychological strategies employed (often unconsciously) to protect a person (the real self or 'ego') from discomfort, uncomfortable emotions, anxiety, or tension that may result from unacceptable thoughts or feelings is considered a defense mechanism. Most individuals use defense mechanisms from time to time, but problems may occur when they are used exclusively or in place of healthier coping mechanisms. Therefore, recognition and nursing interventions focused on adaptive coping strategies should be implemented before working to replace the person's usual defense mechanisms. Defense mechanisms are behaviors that an individual uses to deal with stressors. Defense mechanisms can be beneficial and protective for the patient, or they can be counterproductive and maladaptive. Table 2. Defense mechanisms provides an overview of commonly utilized defense mechanisms; a brief discussion of some of these defense mechanisms follows (https://www.ncbi.nlm.nih.gov/books/NBK559106/)

Table 2. Defense Mechanisms

Defense Mechanism	Definition	Example
Repression	Involuntarily forgetting painful events.	A woman who was sexually abused as a child cannot remember that it occurred.
Suppression	Voluntarily refusing to remember events.	An emergency room nurse refuses to think about the child who is dying from injuries sustained in an auto accident.
Denial	Refusing to admit certain things to oneself.	An alcoholic man refuses to believe that he has a problem, in spite of evidence otherwise.
Rationalization	Trying to prove one's actions are justifiable.	A student insists that poor academic advice is the reason he cannot graduate on time.
Intellectualization	Using logic without feelings.	A father analyzes why his son is depressed without expressing any emotions of concern.
Identification	Attempting to model one's self after an admired other.	An adolescent tries to look and dress like his favorite musician to feel stronger and more in control.
Displacement	Discharging pent-up feelings (usually anger) on another.	A child who is yelled at by her parents goes outside and kicks the dog.
Projection	Blaming someone else for one's thoughts or feelings.	A jealous man states that his wife is at fault for his abuse of her.
Dissociation	Unconsciously separating painful feelings and thoughts from awareness.	A rape victim "goes numb" and feels like she is floating outside of her body.
Regression	Returning to an earlier developmental level.	A 7-year-old child starts talking like a baby after the birth of a sibling.
Compensation	Covering up for a weakness by overemphasizing another trait.	A skinny, nonathletic child becomes a chess champion.
Reaction formation	Acting exactly opposite to an unconscious desire or drive.	A man acts homophobic when he secretly believes he is gay.
Introjection	Taking on values, qualities, and traits of others.	A 12-year-old girl acts like her teacher when the teacher is out of the room.
Sublimation	Channeling unacceptable drives into acceptable outlets.	An angry woman joins a martial arts club and takes lessons.
Conversion	Converting psychiatric conflict into physical symptoms.	A lonely, elderly woman develops vague aches and pains all over.
Undoing	Trying to counteract or make up for something.	A man who yells at his boss sends her flowers the next day to "make up."

(Boyd, 2018)

Denial

Denial indicates an inability to believe or act on some type of news or information. This may be attributed to unconscious forces that override a person's rational thoughts or the premise that changing a behavior is more difficult and anxiety provoking than continuing the behavior. For example, a man with lung cancer may continue to smoke because quitting smoking may mean acknowledging a life-threatening illness, or a woman with alcoholism may continue to drink to avoid facing a dysfunctional marriage. Denial provides protection by allowing the psyche to slowly grasp traumatic events (e.g., death of a loved one), but it becomes maladaptive when the person can't move on. Understanding denial as a psychological process is important, especially when it may seem that a patient is not adhering to a plan of care (https://www.ncbi.nlm.nih.gov/books/NBK559106/).

Repression and suppression

Repression and suppression are defense mechanisms that are commonly confused with each other. In repression, a person cannot voluntarily recall a traumatic event such as a rape or terrorist attack (Halter, 2018). Only through therapy and sometimes hypnosis can the memories start to painfully resurface; when they do, the event will be as acutely distressful as if it had just happened. In suppression, a person chooses to ignore or forget painful events; however, when queried, they can instantly recall them (Halter, 2018). This can be very productive for the nurse in an emergency, when they are able to temporarily push aside personal feelings and reactions to deal with the crisis at hand (https://www.ncbi.nlm.nih.gov/books/NBK559106/).

Displacement

Displacement occurs in our everyday lives. For example, when a person has a bad day at work and goes home and takes it out on their spouse or children, displacement has occurred as the person has shifted their feelings away from the intended object (job, boss, etc.) and onto an innocent and unsuspecting other. Displacement can be the defense mechanism behind anger outbursts such as road rage (https://www.ncbi.nlm.nih.gov/books/NBK559106/).

Rationalizing

Rationalizing is the attempt to explain away situations while not taking responsibility for one's own actions. A senator who is arrested for taking gifts or money from lobbyists may try to rationalize this behavior by saying, *everyone does it, or that's the way you get business done* (https://www.ncbi.nlm.nih.gov/books/NBK559106/).

Identification

An adolescent who tries to emulate a respected authority figure is using identification. Identifying with others and trying to be like them is adaptive and useful when the role model is a positive influence (e.g., father, mother, minister), but it can be very maladaptive when the role model is a negative influence (e.g., gang leader, rock star with drug problems). The psychiatric nurse who understands the various defense mechanisms patients in emotional distress use will be able to develop a treatment plan that addresses the use of defense mechanisms and presents alternatives that are more conducive to mental health and improved quality of life (https://www.ncbi.nlm.nih.gov/books/NBK559106/).

Self-Assessment Quiz Question #3

Which best describes the meaning of defense mechanisms?

a. Behaviors used to deal with stressors.
b. False sensory perceptions.
c. Beliefs that lack substantiation.
d. Overall emotional state.

THERAPEUTIC APPROACHES IN MENTAL HEALTH

Milieu therapy

The word milieu means surroundings or environment; milieu therapy is also referred to as therapeutic community. Milieu therapy is a structuring of the environment in order to affect behavioral changes and improve the psychological health and functioning of the individual. The goal of milieu therapy is to manipulate the environment so that all aspects of a patient's hospital environment are considered therapeutic (Townsend, 2019). Within this setting, the patient is expected to learn adaptive coping, interaction, and relationship skills that can be generalized to other aspects of the patient's life. Although milieu therapy was originally developed for patients in the inpatient setting, these principles have been adapted for a variety of outpatient settings (https://easpublisher.com/media/articles/EASJNM_22_129-135.pdf)

Care of patients in the therapeutic milieu is directed by an interdisciplinary treatment team, but overall management is the responsibility of the nurse. The initial assessment is made by the nurse or psychiatrist and the comprehensive treatment is developed by the treatment team. Basic assumptions of milieu therapy include the opportunity for therapeutic intervention, the powerful use of peer pressure within the environment, and inappropriate behavior can be addressed as it occurs (Boyd, 2018).

There are certain conditions that promote a therapeutic community.

1. The patient is protected from injury from self or others.
2. The patient's physical needs are met.
3. Programming is structured, and routines are encouraged.
4. Staff members remain relatively consistent.
5. Emphasis is placed on social interaction among patients and staff.
6. Decision-making authority is clearly defined.
7. The patient is respected as an individual and is encouraged to express emotion
8. The patient is afforded opportunities for freedom of choice.
9. The environment provides opportunities for testing new behaviors.

(Townsend, 2019;
https://currentnursing.com/pn/milieu_therapy.html)

It is understood that basic physiologic needs are fulfilled, and safety is paramount. Within this environment, a democratic self-government exists through community group participation. This promotes member interaction and communication. The therapeutic milieu provides structure and consistent limit setting at a time when individuals need it the most. These elements provide an assessment of the patient's progress toward treatment goals. The nurse assumes responsibility for the overall management of the therapeutic milieu including assessment, safety and limit setting, medication administration, and education.

Effects of the environment can easily be understood by thinking about common events in one's own life. Going to a party may evoke a sense of festivity, joy, and excitement; going to a funeral can cause somber feelings of sadness; when walking into a quiet library, a person may feel the need to whisper and walk softly; and a starkly painted, tiled hospital room may lead us to feel fearful, anonymous, or disengaged. Even schools reflect environmental or milieu manipulation and effects (consider a Montessori-style school compared with a stricter military school). Inpatient psychiatric settings and residential settings are the most common places in which milieu therapy occurs. A patient who is disorganized, paranoid, or agitated responds better to an environment that is calm, well structured, and predictable, with staff persons who are pleasant in nature but consistent, directive, and firm.

Self-Assessment Quiz Question #4

The nurse is explaining milieu therapy to a group of students. What is the primary role of the nurse in milieu therapy?

a. Conducts individual, group and family therapy
b. Directs drama that portrays real life situations
c. Assumes responsibility for management of milieu
d. Focuses on rehabilitation and vocational training

Group therapy

Irvin Yalom, MD, has been highly influential in the development of group therapy. Dr. Yalom's first book, *The Theory and Practice of Group Psychotherapy* (1970), became a foundational text for many psychotherapists and advanced practice nurses interested in group therapy. Dr. Yalom postulated that when individuals are grouped together, certain characteristics of the individuals will emerge that are reflective of family-of-origin and childhood issues (1970). In therapy sessions with groups of people, these negative or destructive childhood events can be reworked and reframed, leading to healthier adult coping responses while the group members develop identities and go through phases.

In a counseling group setting, members can discuss stressors in a safe environment. The group often provides a sense of community and the feeling that the individual is not alone in dealing with their problems (Corey, Corey, & Corey, 2013). Dr. Yalom termed this concept universality (Yalom & Leszcz, 2014). Thus, universality, or the camaraderie sense of *we are all in this together*, serves to encourage trust and move the group into productivity. Individual group members grow and develop self-awareness through the relationships developed and feedback gathered from those around them (Corey et al., 2013).

Yalom's stages include orientation, conflict development, cohesion, and working (Yalom & Leszcz, 2014). There are many other theories regarding groups; although they may differ in certain ways, they all show how the group forms interpersonal relationships cohesively. The group leader recognizes what phase the group is in and helps facilitate progression toward the group's goals.

The best size for a therapy group is usually 6 to 12 members (Boyd, 2018). In larger groups, some members may be ignored or can more easily avoid participation. In smaller groups, the gatherings can turn into a series of individual therapy sessions with the group leader while everyone else watches. Training in facilitation of therapy groups is standard in graduate programs for advanced practice nurses, psychiatric and psychological master's programs, and clinical doctoral programs.

Psychoeducational groups

Psychiatric nurses are often responsible for facilitating psychoeducational groups in mental health settings, where there is a defined group leader and specific content or topics to be discussed. Topics are frequently based on developing skills important to daily living and maximizing the quality of life. Some topic examples include strategic management of symptoms, medication education, coping with stress, and relapse prevention. Psychoeducational groups emphasize group member interaction and participation, but they also emphasize learning new behaviors. The facilitator may organize hands-on activities and sometimes give homework assignments. Other non-nursing personnel may conduct psychoeducational groups; however, psychiatric nurses are in a unique position based on their education, training, and holistic approaches, to help bridge the gap between patients' physical and mental health. Psychoeducational groups may be larger than strictly therapeutic groups, although larger groups can be difficult to manage depending upon the personality mix of those attending (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7001357/).

Cognitive-behavioral therapy (Individual therapy)

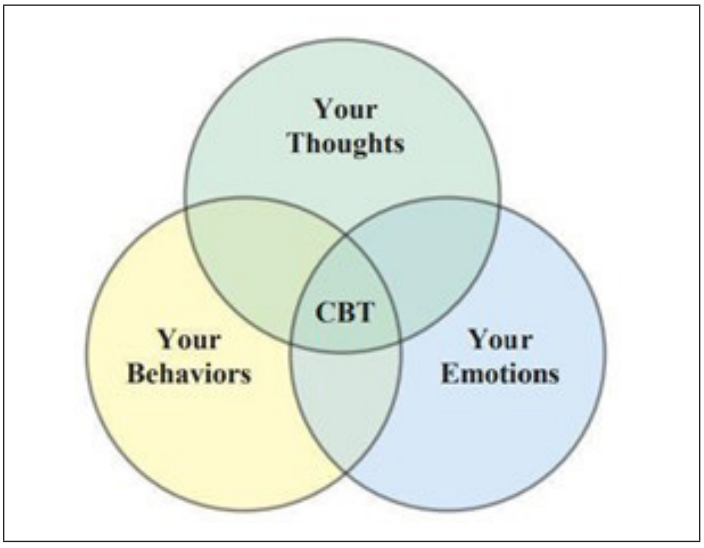
Cognitive-behavioral therapy (CBT), pioneered by Aaron Beck (1967) and Albert Ellis (1973), focused on the relationship between a patient's perceptions about events and the resultant feelings and behaviors. This cycle of thoughts that influence feelings and behaviors is demonstrated in this example:

> *Imagine you are driving down the interstate at 75 miles per hour. You check your rear-view mirror and see the flashing lights of a state trooper. Knowing that you are driving over the speed limit, you are certain you will be pulled over and given a traffic ticket. You think of the two glasses of wine you just consumed with dinner. "What if my blood alcohol level is too high? I can't be arrested! I would lose my job! They'll take away my nursing license!" Your palms get sweaty and your heart starts to race. Barely able to contain your panic, you swerve quickly into the right-hand lane without signaling and cut off a car coming up behind you. The car honks, you pull onto the shoulder, and finally stop. In dread, you look out the window for the trooper, who drives past you down the highway.*

In this example, the driver's thoughts of breaking the law by speeding and getting arrested for drunk driving cause the driver to feel anxious and panic, which results in erratic behavior and nearly causes an accident. Now consider this example:

> *Imagine yourself driving down the interstate. You check your mirror and see the flashing lights of a state trooper. You know you're driving over the speed limit, but so are many drivers around you. You think of the two glasses of wine you had with dinner, but you did eat a large portion and you don't feel drowsy – besides, that was several hours ago. You determine that the state trooper must be on the way to the scene of a crime or accident, so you signal a right turn, check your mirrors, and carefully pull over onto the shoulder of the road. The state trooper drives past you and you continue your journey.*

CBT is based on the supposition that behaviors are a result of distorted thinking about situations (Yalom & Leszcz, 2014). These distortions can take the shape of catastrophizing, which involves thinking that the worst that can possibly happen will happen or has happened; perceiving threats where none exist; thinking only of negative outcomes; or making over-generalizations. In anxiety disorders, fear is the driving force for distorted thoughts. These distorted thoughts impact feelings and lead to behaviors such as situational avoidance where objects or places may become a self-reinforcing behavior as the person has no additional life experience to combat the distorted thinking. Cognitive restructuring is used to help the patient examine their beliefs in more detail and to break down the resultant feelings and behaviors into A (antecedent), B (behavior), and C (consequence).



Exposure is a CBT technique that provokes the patient's anxiety over a feared idea or object in a controlled, supportive environment (Boyd, 2018). A person afraid of heights might be asked to work toward standing on a footstool for a minute or two in the clinician's office. Gradual exposure to the situation allows the patient to systematically desensitize to the stressor with tools to manage thoughts and feelings that arise when confronted with the feared stimulus. Flooding exposes the patient to the stressful object or idea all at once; although this technique can be used, trained clinicians should judiciously use it as it may produce panic symptoms. Skills training may also be employed in CBT. This specifically trains the individual based on their needs. Cognitive-behavioral techniques are useful with most psychiatric conditions and mental health states to improve mental flexibility and resilience, moving the person towards health on the health-illness continuum. Helping the patient to identify beliefs (true or false) about situations enables the patient to challenge the beliefs that are detrimental to recovery (McKay et al., 2015). Psychiatric nurses of all levels can utilize the basic skills of CBT in teaching their patients how to reframe distorted thoughts that lead to emotional turmoil and erratic behaviors.

Family therapy (Social theory)

Individuals with psychiatric, mental health, or behavioral problems often live in a family environment. Children and adolescents are still part of the family unit although the nature of "family" may differ in situations concerning foster care or residential treatment centers. Adults may live alone or with others, be married or single, and live with or without children of their own. Even adults who live alone often have significant family relationships with parents, children, or others. The concept of "family" is identified by the patient but usually involves other persons with whom the patient interacts on a frequent basis and in whom the patient has significant emotional investment.

Family therapy is based within the understanding that, although there is an identified patient, problems may arise out of dysfunctions within the system because the family is a unit and problems are relational to each other (Friedman, Bowden, & Jones, 2003; Sexton & Alexander, 2015). Family therapies focus on strengths of the individual patient and the family as a basis for treatment. Understanding how the family functions and relates to one another helps contribute information that is helpful in the development of a plan of care. Family therapy is complex, and master's or doctorate-level clinicians should be utilized for this type of intense treatment. The Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) offers specialized accreditation to marriage and family therapy programs; this encourages programs to continue monitoring and maintaining their rigor and development and demonstrates that programs are meeting industry standards and their own objectives (COAMFTE, n.d.)

Treating the family via emotional or cognitive methods allows problems to be addressed within the family dynamic; treating the patient apart from his or her family alone will not correct these systemic problems, and relapse is likely (Sexton & Alexander, 2015). Cognitive awareness (as in CBT) helps individuals and families recognize the cyclic nature of thoughts creating feelings, which create behaviors, which reinforce thoughts, and which continue circularly. Addressing this from a systems nature allows all members of the family unit to explore their role within this continuum and work toward healthier interactions simultaneously.

Community support groups (Social theory)

Many community support groups exist to help individuals who are experiencing specific mental health problems. Groups exist for gambling addiction, rape and sexual abuse support, bipolar disorder, depression, grief and bereavement, suicide, attention deficit disorder, PTSD, substance abuse, and many more. Support groups differ from therapy groups in several important ways. Support groups are a network of members with similar traits or characteristics; support groups are leaderless – they may have a nominated leader, but that person is also a victim or patient and a group member; support groups are not managed by a healthcare professional; support groups are free or have minimal cost; support groups may meet less frequently than therapy groups but for a longer period of time (years to indefinitely); and support groups are usually self-sustaining. If members lose interest, the group can't find a place to meet, or membership wanes, then the group may end (https://www.frontiersin.org/articles/10.3389/fpsyt.2021.714181/full).

The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots support organization for families and persons affected by mental illness. Established in 1979, NAMI is a powerful lobbying force in Washington, DC, with affiliates in every state and more than 1,100 communities across the country. NAMI focuses on fighting against the stigma associated with mental illness and provides support for families and patients with psychiatric illnesses.

Self-Assessment Quiz Question #5

Which of the following is considered a support group?

a. Cognitive behavioral therapy.
b. Alcoholics Anonymous.
c. Family therapy.
d. Medication education.

BRAIN ANATOMY AND PHYSIOLOGY

Within the brain, several areas influence behaviors and are related to psychiatric-mental health disorders, such as the areas involved in mood, anger, and thoughts. Therefore, it is important for nurses to understand how the brain regulates mood and behaviors. The cortex, the outer surface of the brain, is associated with rational thinking (Halter, 2018). The orbitofrontal cortex, which is in the forehead, regulates sympathetic and parasympathetic signals and houses the executive functions (Norris, 2019). Examples of executive functions include decision making, organizing, and determining right from wrong. Additionally, the cortex is adjacent to other areas of the brain, connecting rational thought to mood.

Several other areas of the brain also have a role in psychiatric-mental health disorders. The frontal lobe, for example, is heavily involved in decision making. The parietal lobe integrates sensory and motor information. The occipital cortex is the vision center. The cerebellum works to create muscle tone, posture, and coordination. The temporal lobe is involved with memory, smells, sounds, and language. The hypothalamus regulates body temperature and metabolism, and research suggests that it plays a role in emotions. The pituitary gland regulates hormones, and the brainstem controls basic vital functions such as respiratory rate, heart rate, reflexes, and movement (Norris, 2019).

The limbic system, which is involved in emotions, has a central role in psychiatric-mental health disorders. The limbic system contains the amygdala, which regulates mood and emotions such as anger; the hippocampus, which regulates memory; and the anterior cingulate, which regulates sensations (Norris, 2019; Stahl, 2020). These areas all work together to compose emotions and the body's responses to emotions. There are millions of connections among these areas. These connections, or pathways of electrical impulses, allow parts of the brain to communicate with one another and respond to stimuli.

NEUROTRANSMITTERS

The presynaptic area located at one end of each neuron holds neurotransmitters. A neurotransmitter is a chemical that carries a message to another neuron. An electrical charge, usually powered by a sodium-potassium channel, causes a reaction from one end of the neuron to the other, releasing the neurotransmitter into the synapse like a gun firing (Norris, 2019; Stahl, 2020). The neurotransmitter then crosses the space or synapse between the neurons and attaches to a specific receptor on the postsynaptic cell. Once the neurotransmitter has delivered the message to the postsynaptic cell, it is released back into the synapse (Stahl, 2020). Once released, the neurotransmitter can be destroyed by specific enzymes or be taken back into the presynaptic area by a process called *reuptake* (Stahl, 2020).

Psychiatric-mental health treatment is based on enabling neurotransmitters with messages to attach to the postsynaptic neurons (Stahl, 2020). Each neurotransmitter attaches to a receptor like a key fitting into a lock. This causes a reaction in the neuron referred to as a *second messenger system*. These exchanges must happen several times before the goal of change in the neurons and brain occurs. Sometimes a message gets lost or is incorrectly transmitted. This can lead to emotional dysregulation and psychiatric symptoms (Stahl, 2020).

Dopamine, serotonin, and norepinephrine are the most important neurotransmitters in mental health. In addition, two amino acids, gamma-aminobutyric acid and glutamate, have a role in psychiatric-mental health, with each having its own effect on mood and behavior.

Dopamine

Dopamine is a neurotransmitter associated with psychosis and influences several areas of the brain. Dopamine regulates movement and coordination, emotions, and decision making. Decreased levels of dopamine can cause Parkinson's disease. Conversely, increased levels can lead to schizophrenia or mania (Stahl, 2020). Dopamine also stimulates the hypothalamus to release sex, thyroid, and adrenal hormones (Stahl, 2020). Antipsychotic medications aim to decrease symptoms of psychosis by enhancing the impact of dopamine on the postsynaptic cells.

Serotonin

Serotonin is a neurotransmitter found in the limbic system, the brain cortex, and the stomach. Research suggests that low levels of serotonin are implicated in depression, whereas excess levels have a role in anxiety, mania, aggression, and possibly schizophrenia. Serotonin is also associated with appetite, mood, aggression, libido, sleep, and arousal, as well as perception of pain (Stahl, 2020). Medications that support serotonin are the first line of action against depression and are components of some antipsychotic medications.

Norepinephrine

Norepinephrine is a neurotransmitter found in various parts of the brain and the brainstem. Norepinephrine regulates mood, cognition, perception, sleep, arousal, and cardiovascular status (Stahl, 2020). Excess levels can trigger a fight-or-flight response and long-term elevations are associated with mania and anxiety. When norepinephrine is depleted, depression can occur. Research suggests that norepinephrine plays a role in the chronic pain that can accompany depression. Medications that increase the messages or actions of receptors that involve norepinephrine are usually antidepressants.

Gamma-Aminobutyric Acid

Gamma-aminobutyric acid (GABA), an amino acid, is an inhibitory protein. It is concentrated in the frontal and temporal lobes of the brain, where it slows down activity. GABA works like a light switch, turning on and off other excitatory molecules (Stahl, 2020). When there is not enough GABA in the brain, anxiety can occur. Medications such as benzodiazepines aim to increase levels of GABA to slow down the brain activity involved in, for example, panic attacks and anxiety.

Glutamate

Glutamate is an excitatory amino acid that functions to open the calcium channel so that neurons fire faster (Stahl, 2020). This causes excitement in the brain. Researchers are currently investigating the role of glutamate in ADHD, anxiety disorders, depression, mania, and mood disorders (Stahl, 2020).

Self-Assessment Quiz Question #6

Dopamine is responsible for which of these symptoms?

a. Sleep.
b. Psychosis.
c. Arousal.
d. Catatonia.

PSYCHOPHARMACOLOGY AND THE BRAIN

Typically, medications that treat psychiatric-mental health disorders work by either increasing or decreasing the activity of neurotransmitter receptor systems in several ways (Stahl, 2020). For example, benzodiazepines aim to slow down brain activity, thus reducing anxiety, by increasing levels of GABA. It is important to remember that the change in the neurotransmitter system either facilitates or inhibits different functions in the brain. Medications can have a single specific target, such as serotonin reuptake inhibitors, or they can target multiple transporters, such as serotonin and norepinephrine reuptake inhibitors.

Simply stated, psychiatric medications block receptors or increase the number of neurotransmitters available for use, thus changing the message at the postsynaptic site. For example, consider a patient with depression who takes a selective serotonin reuptake inhibitor (SSRI). The medication increases the serotonin in the synapse, making more serotonin available for the receptors (Stahl, 2020). The message is sent via the postsynaptic cell and a second messenger to change the cell. The result is a decrease in depressed mood. Note that it might take several weeks of changes to this system for the desired health outcome to occur (Stahl, 2020).

Because neurons and the messages they carry are interrelated, even medications that target only one neurotransmitter can affect other neurotransmitters and messages. These alterations can cause changes in basic drives, sleep patterns, body movements, and autonomic functions (Stahl, 2020). These are side effects of medications affecting neurotransmission. For example, several psychotropic medications have the side effect of drowsiness. This occurs because the medication affects more than one neurotransmitter and message. Side effects are often the result of unintended changes in the neurotransmitter systems.

Classifications in psychopharmacology

Medications play a role in the treatment of nearly every psychiatric condition. For the purposes of this course, psychotropic medications are classified into seven broad categories: antidepressants, anti-anxiety agents (also called anxiolytics), antipsychotics and their "partners" anticholinergics (used to reverse some side effects), mood stabilizers, sedative-hypnotics, psychostimulants, and miscellaneous medications designed to reduce or prevent alcohol or drug dependence, including nicotine dependence (Stahl, 2021)

Complementary and alternative therapies in mental health

Herbals and dietary supplements have gained interest in Western cultures as people search for natural remedies. Many people feel that natural herbal remedies are healthier and safer overall than pharmaceutical drugs. The Food and Drug Administration (FDA) considers herbal supplements, vitamins, and other dietary supplements to be food sources and, as such, only monitors information on the product's label and does not regulate their manufacturing or usage. This can result in wide variances in the amount of active ingredient that may be available in a certain product; some products have even been found to contain no active ingredients after undergoing laboratory evaluation. Some herbal supplements have been used in the treatment of mental health conditions, as these products are available over the counter in many stores. Patients may seek information available on the Internet and then choose supplements based upon their understanding. The nurse should always assess the use of herbal and other supplements and educate patients about known mechanisms of action, side effects, and possible interactions with pharmaceutical drugs. It is important to review available research regarding supplements and use this evidence when providing patient education. The role of certain natural herbs in the treatment of psychiatric disorders is discussed below.

St. John's wort (*Hypericum perforatum*) is derived from the St. John's wort plant. It is primarily used to address depression. St. John's wort is thought to affect serotonin and monoamine oxidase inhibitors in the brain, similar to antidepressants. There are numerous studies that demonstrate reports of drug-to-drug interactions in patients who used St. John's wort while taking other medications (including prescribed antidepressants), so it is important that the nurse teaches patients not to combine this supplement with other medication, as it may increase the risk for serotonin syndrome.

Valerian root (*Valeriana officinalis*) is powdered and taken in a capsule form. It is believed to work on the gamma-aminobutyric acid (GABA) system to alleviate anxiety and treat insomnia. Valerian should not be taken with other central nervous system depressants (especially anesthetics, barbiturates, and benzodiazepines) because it can potentiate their effects. Side effects include headaches, uneasiness, dizziness, and, sometimes, excitability.

Kava kava (*Piper methysticum*) is a South Pacific oceanic herb with sedative, analgesic, and mild euphoria-inducing properties. Kava kava may act on GABA in a manner similar to benzodiazepines, and it does have drug-to-drug interaction effects with those products. Side effects of kava kava can include stomach disturbances, dizziness, and a temporary yellowing of the skin. A person with liver impairment or one who is a heavy alcohol user should never use kava kava because it has been linked with hepatotoxicity (Rivers, Xing, & Narayanapillai, 2016). Banned in some European countries, kava kava is still widely available for over the counter or Internet purchase in the United States, Australia, and New Zealand (Rivers et al., 2016).

Ginseng (*Panax ginseng*) is a stimulating herb that can produce energy similar to caffeine, meant to result in improved endurance and reduced fatigue. Jitteriness and nervousness can be side effects of this supplement, as can insomnia, hypertension, restlessness, and, possibly, mania.

Ginkgo biloba (*Ginkgo biloba*) has gained popularity for its theoretical ability to improve blood flow to the brain to promote alertness, mental sharpness, and memory; to treat fatigue and stress; and to improve endurance. Ginkgo biloba has antioxidant properties, reducing free radicals in the body that cause cellular death (Tulsulkar & Shah, 2013). Ginkgo biloba can interfere with blood clotting and reduce platelet action, leading to increases in bleeding times. It may interfere with anticoagulant therapy and should not be taken by patients with circulatory problems who are taking such medications such as Coumadin, Plavix, or aspirin. Side effects of ginkgo biloba include headaches, nausea, vomiting, stomach upset, and, occasionally, skin allergies (Izzo, Hoon-Kim, Radhakrishnan, & Williamson, 2016).

Chamomile preparations are often used in Europe to facilitate digestion, ease gas, and decrease cramping (Mahady, Wicks, & Bauer, 2017). It has been shown to be safe for children and is a first line of therapy in Germany for treating sensitive skin infants and young children (Mahady et al., 2017).

To address vitamin and mineral needs, a one-a-day multivitamin supplement for adults and a chewable daily supplement for children can be helpful. Iron deficiency is associated with fatigue and oral conditions such as stomatitis. Omega-3 fatty acids (fish oil, flaxseed oil) have shown positive benefits in treating behavioral problems (Bondi et al, 2014; Raine, Portnoy, Liu, Mahoomed, & Hibbeln, 2015). The fat-soluble vitamins A, D, and K can be dangerous in high doses. B-complex vitamins are associated with energy. Given with calcium, vitamin B6 has been shown to reduce premenstrual symptoms (Masoumi, Ataollahi, & Oshvandi, 2016). L-methylfolate (Deplin), a prescription medical food, is a derivative of folic acid (a B vitamin). It is a dietary supplement that has demonstrated effectiveness in enhancing the treatment of depression and is monitored by the FDA (Shelton, Manning, Barrentine, & Tipa, 2013).

Massage is the manipulation of the body's soft tissues to promote circulation and relaxation. There are numerous types of massage techniques, varying from light touch to deep muscle work and from specific to generalized body parts. Swedish massage is meant to provide relaxation and increase circulation; Shiatsu massage, influenced by Chinese medicine, is used by a specialized practitioner who applies pressure to acupoints on the body with the intention of increasing the life flow (or Japanese ki; Halter, 2018).

Reflexology, also called *zone therapy*, is the application of massage or pressure to the hands and feet to alleviate distress in different parts of the body. The theory of reflexology is that all of the body is represented in areas in the hands and feet, and thus stimulating these trigger points can eliminate distress in the related body system(s) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4624523/).

According to traditional Chinese medical theory, acupuncture points are situated along meridians (channels) in the body that align with a vital energy flow, the *Qi* (Halter, 2018). Illness or distress interrupts the Qi. Acupuncturists insert tiny filiform needles along the meridians to stimulate and readjust the energy flow. Practitioners diagnose which systems in the body are affected based on inspection, auscultation, olfactory senses, palpation, and taking a limited history of symptoms. Side effects to the treatment are generally mild and may include slight headaches, nausea, or pain in certain areas. In the Western hemisphere, a common use of acupuncture is for the treatment of pain (Halter, 2018 (https://www.sciencedirect.com/science/article/pii/S2213422021000883?via%3Dihub).

Hypnosis is a technique that induces a deep relaxation and calm, trance-like state of mind. The patient's focus of awareness becomes so restricted that external noise and distractions are no

longer present in the conscious mind. Hypnotherapy is practiced by highly trained clinicians, often psychologists, to achieve certain therapeutic goals with the patient, such as recovering memories lost through the defense mechanism of repression, learning to be less anxious when faced with anxiety-provoking situations, or reducing or eliminating undesirable behavior such as smoking. The patient undergoing hypnotherapy must be relaxed and receptive to the procedure (https://positivepsychology.com/hypnotherapy/).

Psychiatric nurses should familiarize themselves with the various modalities of psychotherapy, the medications used in the treatment of psychiatric illness, as well as the complementary and alternative therapies and the various somatic therapies used in the treatment of psychiatric disorders. Psychiatric nurses provide psychoeducational services to patients and their families and should have a thorough understanding of the treatment modalities commonly used in psychiatric practice.

Self-Assessment Quiz Question #7

Which complementary alternative medicine interferes with anticoagulants?

a. Chamomile.
b. Ginseng.
c. Ginkgo biloba.
d. St. John's wort.

Self-Assessment Quiz Question #8

Which complementary alternative medicine should be avoided in patients who report heavy alcohol use?

a. St. John's Wort.
b. Ginseng.
c. Valerian root.
d. Kava kava.

OTHER THERAPIES IN MENTAL HEALTH

Electroconvulsive therapy

Mental health professionals once used ECT, introduced in the 1930s, to treat a broad range of psychiatric disturbances (George et al., 2020). With strong advances and refinements in the field, professionals may still use ECT to treat certain conditions such as severe depression (major depression), mania, or psychosis (George, et. al, 2020). To perform ECT, the patient is given a short-acting sedative, followed by a muscle relaxant. The muscle relaxant prevents tonic-clonic jerking of the body caused by seizure activity that, historically, was the cause of physical injuries to the patient. After the patient is anesthetized, electrodes are placed on the sides of their head and an electrical stimulus that is sufficient to trigger a seizure is given. Ideally, the seizure activity lasts about 15 seconds (Townsend, 2014). Breathing is supported during the procedure by nurse anesthetists or anesthesiologists. The ECT session is repeated two to three times a week for 3 to 4 weeks and is often done on an outpatient basis (Townsend, 2019).

Providers usually use medications and therapy before deciding to use ECT. ECT has an effectiveness rate of approximately 60% to 70% in the treatment of depression (George, et. al, 2020). There are few contraindications to ECT; however, caution should be used in pregnancy, patients with cardiac conditions, or patients with intracranial pressure because of disease (Townsend, 2019). Side effects of ECT include memory loss and some confusion in recalling events right before and after the procedure. Some people complain of long-term memory and cognitive problems. Also, complications related to the use of anesthetics (allergic reaction, respiratory suppression) can occur.

Transcranial magnetic stimulation

Transcranial magnetic stimulation (TMS) is a noninvasive treatment for depression. The patient is exposed to electrical energy that is passed through a coil of wires to produce a powerful magnetic field (George, et. al, 2020). Magnetic waves pass through the brain and skull painlessly, while the patient remains awake for the procedure. It is most effective when administered for 40 minutes daily for 4 to 6 weeks. It is thought to work by stimulating nerve cells to produce the neurotransmitters that relieve depression. Side effects of TMS are few, with patients reporting only mild headaches. TMS cannot be used if the patient has implanted or permanent metal in the skull or brain (George, et. al, 2020).

Vagus nerve stimulation

Vagus nerve stimulation (VNS) is an adjunctive, long-term, invasive therapy for adult patients with serious and persistent depression (George, et. al, 2020). Most of these individuals have shown no improvement in condition after trials of four or more antidepressants before attempting VNS therapy. A VNS implant is a small, battery-powered device, similar to a cardiac pacemaker, that is surgically implanted subcutaneously under the skin of the upper left or right chest. Internally, a wire runs from the device to the vagus nerve, which then carries electrical impulses to the brain. These impulses are emitted every few minutes. The device is thought to work by electrically stimulating the production of neurotransmitters that are associated with depression treatment. The side effects of VNS include a tickle in the throat (may trigger a cough reflex), mild hoarseness or other voice changes, and, rarely, difficulty swallowing, shortness of breath, neck pain, and a prickling sensation in the skin.

Case study 1

Mrs. Jones was admitted as an involuntary patient to the psychiatric unit. She was brought to the emergency department by her daughter, who reported her mother was showing "new and bizarre" behaviors. She has a history of schizophrenia, which has been well controlled until this episode.

The psychiatric nurse begins the mental status exam of Mrs. Jones. The nurse notes that she is wearing a short dress that is on backwards. She appears disheveled and unkempt; she has not eaten any of her breakfast. Further, the nurse observes that Mrs. Jones has taken the blankets off the bed and laid them out on the floor. She has also taken the toilet paper and unrolled it into a pile on the floor.

When the nurse introduces herself, Mrs. Jones is at the window talking in nonsensical words. She is wringing her hands and appears to be fixated on something outside. She does not acknowledge the nurse.

Later, she turns around and exclaims, "Sally, I am so glad you are here. Tea is almost ready. Flubrubaroo?" She moves to the pile of blankets and stands in the middle of them, smiling at the nurse.

The nurse smiles and begins to talk to Mrs. Jones. The nurse explains again that she is a psychiatric nurse and is there to care for her. She states, "Oh no, dear, have you tokenitnd?"

The nurse notes that Mrs. Jones' affect is flat as she stares out at the window but animated when speaking in nonsensical words. The nurse asks her name. Suddenly, the patient turns to the nurse and starts talking very quickly, saying, "I know it is late. What was the dog's name again? I must go to the store. More milk."

Questions
1. Which components of the mental status examination can the nurse document from this interaction with Mrs. Jones?
2. How might you describe Mrs. Jones' affect?
3. How would you summarize the nurse's observation and evaluation of Mrs. Jones' thought processes?
4. What other health status information is helpful for the nurse to assess?

Responses
1. The psychiatric nurse can document Mrs. J's appearance, her behavior, and her affect, but not her mood. Documentation can also include thought processes and thought content. The psychiatric nurse is unable to assess Mrs. J's memory, cognition, insight, motivation, and judgment as well as her safety.
2. In addition to being flat and animated, Mrs. J's affect may also be described as anxious. Because her affect seems to be fluctuating, there may be an incongruence between her affect and behavior.
3. Word salad is a common finding and learners should be familiar with the term. Mrs. J's nonsensical and disorganized speech gives some indication of her thought processes. Her thought process appears to be confused. She exhibits word salad and her thought processes are disjointed and incoherent. Mrs. J's thought content is not clear as she does not respond coherently to the questions being asked.
4. It would be helpful for the psychiatric nurse to obtain information from the patient's daughter. What has Mrs. J been exhibiting at home? What is Mrs. J's baseline level of functioning? Were there any past episodes of self-harm or dangerous behavior? Over what period has this change in behavior occurred? Were there any triggers?

Case study 2

Donald is a 45-year-old male patient employed as a financial manager by a large bank. Because of economic downturns, there have not been as many opportunities to gain new business, which has led to fierce competition between financial managers.

Donald presents to his primary care provider's office reporting recent episodes of shortness of breath, sweating, anxiety, and the strong feeling that he is about to die. These symptoms started 3 months ago, occurring once or twice a week. Within the past few weeks, Donald reports he has experienced symptoms daily and he has begun to fear leaving his home because he is afraid that he will have another attack. His attendance at work has suffered and he reports that his supervisor told him that he might lose his job as a result. This has caused problems between him and his wife and she has started talking about leaving him to move back in with her parents.

An electrocardiogram, stress test, and laboratory testing are performed, all of which show normal results. Donald is prescribed alprazolam (Xanax) by his primary care provider and referred to the local mental health center for treatment. Once there, he meets with a therapist for a comprehensive assessment. Donald is diagnosed with panic disorder and agoraphobia. He is referred to the psychiatric nurse practitioner for a medication evaluation and treatment. The nurse practitioner recommends that Donald start taking sertraline (Zoloft), 50 mg daily, and that he uses the Xanax only as needed to avoid tolerance and dependency.

Questions
1. What are other therapies that are most likely to be beneficial for Donald?
2. Are there any ancillary services that could also be helpful to Donald?
3. Which recommendations regarding his relationship status with his wife could the nurse practitioner discuss with Donald?

Responses
1. Panic attacks and panic disorder are treatable and respond well to medications and therapy. Cognitive-behavioral therapy is indicated to help this patient learn to identify anxiety-provoking triggers and reframe how he thinks about these events. Relaxation training, such as guided imagery and mindfulness, could be helpful in teaching Donald a means of reducing the anxiety once it occurs.
2. Another recommendation for Donald would be to include regular daily exercise in his routine (aerobic or weightlifting) because exercise can have a significantly positive effect on panic disorder treatment.
3. Donald may wish to consider the need for marital therapy sessions to work on improving communication with his wife. If she is willing to participate in Donald's treatment plan, they may also want to join a National Alliance on Mental Illness (NAMI) support group to learn more about psychiatric disorders and the rights of individuals who have such disorders. Finally, mental and behavioral health problems are considered medical problems and are protected under the federal Family and Medical Leave Act of 1993. If Donald's symptoms increase and become more debilitating, the psychiatric nurse practitioner treating Donald can provide him with a work statement and absence excuse that should help to protect his employment status and prevent him from losing his job while he is receiving treatment.

Case study 3

Mr. Fisher is a young adult male patient who has been newly diagnosed with panic attacks. The psychiatric mental-health nurse working in the outpatient clinic meets with Mr. Fisher, who was recently prescribed benzodiazepine by the psychiatrist for his panic attacks. Mr. Fisher asks the nurse what it means to have "a chemical imbalance" in the brain. He also asks how the new medication will "fix" his panic attacks.

Questions
1. How should the nurse explain "a chemical imbalance" in the brain to Mr. Fisher?
2. How should the nurse describe how benzodiazepine medications work?

Responses
1. The psychiatric-mental health nurse should explain to Mr. Fisher that neurotransmitters are chemicals in the brain that form messenger systems between neurons to help the brain and body regulate functions (e.g., thinking, feeling) and react or behave. The nurse also explains that there are excitatory and inhibitory amino acids that assist in regulating these brain functions. The nurse describes that a person's emotions and behaviors are the result of the functioning of these chemicals carrying messages between the neurons and amino acids. When there is an imbalance among neurotransmitters, the messenger system receives too many or too few messages, impairing regulation.
2. The nurse should explain that, in a person with panic disorder, the function of GABA may be altered. Normally, GABA slows down other chemicals that are more excitatory. If GABA is not working correctly or at the correct level, there is no way to slow down the other chemicals. The result may be panic attacks. There are anti-anxiety medications, such as benzodiazepines, that aim to increase levels of GABA to help slow down brain activity; they decrease anxiety by changing how the chemicals in the brain communicate and work.

Healthcare Considerations

1. Therapeutic use of self is one of the foundations of mental health nursing.
2. An understanding of the mental health exam is fundamental to the diagnosis and treatment of mental illness.

Conclusion

The brain is an amazing organ that not only monitors changes in the external world but also regulates internal body functions. The brain initiates basic drives and controls contractions of muscles, internal organs, sleep cycles, moods, and emotions. Knowledge of how the brain works with regard to neurotransmission is an important aspect of understanding psychiatric-mental health disorders and the medications used to alleviate patient symptoms. Neurotransmitters carry specific messages from neuron to neuron to produce emotions and behaviors. Psychiatric-mental health medications work by altering these messenger systems. The neurotransmitters involved in mood and behavior include serotonin, norepinephrine, and dopamine. Through epidemiological research, healthcare providers can learn more about the prevalence of psychiatric and mental health disorders, as well as ways to identify persons who are at risk. This information becomes an important part of the nurse's assessment and identification of patients with psychiatric disorders. Recognizing an individual's behaviors and making statements can add to the assessment data and provide insight into the patient's current mental health state.

Assessing the patient, performing mental status assessments, identifying priority problems, developing goals and objectives, and developing evidence-based plans of care comprise the core steps of the systematic approach to caring for patients with psychiatric disorders. After these processes have taken place, the provision of relevant and appropriate nursing interventions follows. The therapeutic relationship is established during initial patient encounters, during the assessment and implementation of interventions during the nursing care planning process.

Psychiatric nurses who use therapeutic communication will be able to conduct effective, comprehensive mental status examinations that provide the information necessary to develop a comprehensive mental healthcare plan, regardless of practice setting.

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BASIC PSYCHIATRIC CONCEPTS

Self-Assessment Answers and Rationales

1. The correct answer is B.
Rationale: Aaron Beck developed cognitive behavioral therapy after working with depressed patients. Cognitive behavioral therapy is based on cognitive psychology and behavioral therapy.

2. The correct answer is A.
Rationale: The unit policy regarding voluntary patient participation in group therapy preserves the ethical principle of autonomy. The principle of autonomy presumes that individuals are capable of making independent decisions for themselves and that healthcare workers must respect these decisions. Beneficence refers to one's duty to benefit or promote the good of others. Justice reflects the nurse's duty to treat all patients equally. Veracity refers to the duty to be truthful (Boyd, 2018).

3. The correct answer is A.
Rationale: Defense mechanisms are behaviors that an individual uses to deal with stressors. Defense mechanisms can be beneficial and protective for the patient or they can be counterproductive and maladaptive.

4. The correct answer is C.
Rationale: The nurse assumes responsibility for the milieu. The nurse is responsible for the overall environment as well as assessment and medication administration. The therapist is primarily responsible for group and individual therapy in a traditional care model. Psychodrama uses role-play to express feelings. The occupational therapy assists the patient to develop independence in life skills. (Boyd, 2018)

5. The correct answer is B.
Rationale: Many community support groups exist to help individuals who are experiencing specific mental health problems. Groups exist for gambling addiction, rape and sexual abuse support, bipolar disorder, depression, grief and bereavement, suicide, attention deficit disorder, Tourette's disorder, substance use disorders, and many more.

6. The correct answer is B.
Rationale: Dopamine is a neurotransmitter associated with psychosis and influences several areas of the brain.

7. The correct answer is C.
Rationale: Ginkgo biloba can interfere with blood clotting and reduce platelet action, leading to increases in bleeding times. It may interfere with anticoagulant therapy and should not be taken by patients with circulatory problems who are taking such medications such as Coumadin, Plavix, or aspirin.

8. The correct answer is D.
Rationale: A person with liver impairment or one who is a heavy alcohol user should never use kava kava because it has been linked with hepatotoxicity (Rivers, Xing, & Narayanapillai, 2016)

Cultural Humility for Healthcare Professionals

3 Contact Hours

Release Date: October 27, 2021

Expiration Date: October 27, 2024

Faculty

Adrianne E. Avillion, D.Ed, RN, is an accomplished nursing professional development specialist and healthcare author. She earned a doctoral degree in adult education and an MS in nursing from Penn State University, and a BSN from Bloomsburg University. Dr. Avillion has held a variety of nursing positions as a staff nurse in critical care, physical medicine, and rehabilitation settings, as well as numerous leadership roles in professional development. She has published extensively and is a frequent presenter at conferences and conventions devoted to the specialty of continuing education and nursing professional development. Dr. Avillion owns and is the CEO of Strategic Nursing Professional Development, a business that specializes in continuing education for healthcare professionals and consulting services in nursing professional development.

Adrianne E. Avillion has disclosed that she has no significant financial or other conflicts of interest pertaining to this course.

Content Reviewer: Mary C. Ross, PhD, RN, is an experienced nursing educator with extensive clinical experience in multiple areas of nursing including community and mental health. She is a retired Air Force flight nurse and previous chair of a national Veterans Administration advisory council. She has extensive experience living and working in foreign countries and with diverse patient populations.

Mary C. Ross has disclosed that she has no significant financial or other conflicts of interest pertaining to this course.

Course overview

The purpose of this education program is to present an introduction to cultural humility and offers tools for healthcare professionals to use when working with diverse patients in a culturally humble manner.

Learning objectives

Upon completion of this course, the learner should be able to:

- Define cultural humility.
- Describe dimensions of diversity in the United States.
- Identify factors that can interfere in the healthcare professional/patient relationship with patients of diverse cultural backgrounds.
- Explain cultural humility from the perspectives of oppression, privilege, and marginalization.
- Describe the process of providing patient care with cultural humility.
- Differentiate between multicultural competency and cultural humility.

How to receive credit

- Read the entire course online or in print which requires a 3-hour commitment of time.
- Complete the self-assessment quiz questions which are at the end of the course or integrated throughout the course. These questions are NOT GRADED. The correct answer is shown after you answer the question. If the incorrect answer is selected, the rationale for the correct answer is provided. These questions help to affirm what you have learned from the course.
- Depending on your state requirements you will be asked to complete either:
  - An affirmation that you have completed the educational activity.
  - A mandatory test (a passing score of 70 percent is required). Test questions link content to learning objectives as a method to enhance individualized learning and material retention.
- If requested, provide required personal information and payment information.
- Complete the MANDATORY Course Evaluation.
- Print your Certificate of Completion.

CE Broker reporting

Colibri Healthcare, LLC, provider # 50-4007, reports course completion results within 1 business day to CE Broker. If you are licensed in Arkansas, District of Columbia, Florida, Georgia, Kentucky, Michigan, Mississippi, New Mexico, North Dakota, South Carolina, or West Virginia, your successful completion results will be automatically reported for you.

Accreditations and approvals

Colibri Healthcare, LLC is accredited as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation.

Individual state nursing approvals

Colibri Healthcare, LLC is accredited as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation. In addition to states that accept courses offered by ANCC accredited Providers, Colibri Healthcare, LLC is an approved Provider of continuing education in nursing by: Alabama Board of Nursing, Provider #ABNP1418 (valid through February 5, 2025); Arkansas State Board of Nursing, Provider #50-4007; California Board of Registered Nursing, Provider #CEP17480 (valid through January 31, 2024); California Board of Vocational Nursing and Psychiatric Technicians (LVN Provider #V15058, PT Provider #V15020; valid through December 31, 2023); District of Columbia Board of Nursing, Provider #50-4007; Florida Board of Nursing, Provider #50-4007; Georgia Board of Nursing, Provider #50-4007; Kentucky Board of Nursing, Provider #7-0076 (valid through December 31, 2023; CE Broker Provider #50-4007); Michigan Board of Nursing, Provider #50-4007; Mississippi Board of Nursing, Provider #50-4007; New Mexico Board of Nursing, Provider #50-4007; North Dakota Board of Nursing, Provider #50-4007; South Carolina Board of Nursing, Provider #50-4007; and West Virginia Board of Registered Nurses, Provider #50-4007. This CE program satisfies the Massachusetts States Board's regulatory requirements as defined in 244 CMR5.00: Continuing Education.

Activity director

Shirley Aycock, DNP, RN, Executive Director of Quality and Accreditation

Disclosures

Resolution of conflict of interest
In accordance with the ANCC Standards for Commercial Support for continuing education, Colibri Healthcare, LLC implemented mechanisms prior to the planning and implementation of the continuing education activity, to identify and resolve conflicts of interest for all individuals in a position to control content of the course activity.

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The information provided in this activity is for continuing education purposes only and is not meant to substitute for the independent medical judgment of a healthcare provider relative to diagnostic and treatment options of a specific patient's medical condition.

Course verification

All individuals involved have disclosed that they have no significant financial or other conflicts of interest pertaining to this course. Likewise, and in compliance with California Assembly Bill No. 241, every reasonable effort has been made to ensure that the content in this course is balanced and unbiased.

DEFINITION OF CULTURAL HUMILITY

In the context of healthcare services cultural humility is defined as "a process of being aware of how people's culture can impact their health behaviors and, in turn, using this awareness to cultivate sensitive approaches in treating patients" (Prasad et al., 2016). In contrast, cultural competency is described as ensuring that healthcare professionals learn a quantifiable set of attitudes that allow them to work effectively within the cultural context of each patient. There is an end point to cultural competency. It ends with the termination of the healthcare professional-patient relationship. On the other hand, cultural humility is an ongoing process, which requires continual self-reflection and self-critique. Cultural humility is a prerequisite to cultural competency. It forms a basis for effective, harmonious healthcare professional-patient relationships (Prasad, 2016).

Cultural humility involves entering into a professional relationship with a patient by honoring the patient's beliefs, customs, and values. Cultural competency is described as a skill that can be taught, trained, and achieved. This approach is based on the concept that the greater the knowledge a healthcare professional has about another culture, the greater the competence in practice. Cultural humility de-emphasizes cultural knowledge and competency and focuses on lifelong nurturing of self-reflection and self-critique, promotion of interpersonal sensitivity, addressing power imbalances, and promoting the appreciation of intracultural variation and individuality (Stubbe, 2020). This humility exemplifies respect for human dignity.

An important part of cultural humility is identifying one's own biases, self-understanding, and interpersonal sensitivity. It is important that healthcare professionals nurture an appreciation for the many facets of each patient, including culture, gender, race, ethnicity, religion, sexual identity, and lifestyle. According to Yancu (2017), healthcare professionals need both process (cultural humility) and product (cultural competence) to effectively provide care and interact with a culturally diverse society.

Healthcare Professional Consideration: A culturally humble healthcare professional needs to be able to provide services that transcend culture, ability, LGBTQ status, and class, as well as integrate healthcare professional-stated cultural and other considerations into treatment. Moreover, the healthcare professional must recognize the roles that power, privilege, and oppression play in both the counseling relationship and the experiences of patients (Sue & Sue, 2021).

Self-Assessment Quiz Question #1

Which of the following statements pertains to the definition of cultural humility?

a. Healthcare professionals must learn a quantifiable set of attitudes.
b. Cultural humility is an ongoing process.
c. Cultural humility is a skill that can be taught.
d. Healthcare professionals know that there is an end point to cultural humility.

DIMENSIONS OF DIVERSITY IN THE UNITED STATES

Definitions

Diversity is a multidimensional concept that refers to many aspects of an individual that combine to comprise an overall sense of self. Moreover, diversity occurs within a cultural and social context where variances within the general population are treated differentially based on the social, political, and cultural constructs existing within a society. Some dimensions of diversity include race, socioeconomic class, gender, sexual orientation (i.e., identifying as lesbian, gay, bisexual, queer/questioning [LGBQ]), gender identification (i.e., identifying as transgender), and disability. Although this is not an exhaustive list of all elements of individual diversity, it does address many prominent dimensions of diversity an individual may have as well as determine where that individual falls within the societal hierarchy. Dimensions of diversity also serve to privilege and empower some members of society while oppressing and marginalizing other members of society (Sue & Sue, 2021).

Intersectionality is a concept that is used to describe how these various dimensions come together to privilege or oppress individuals and groups of individuals. Intersectionality is defined as "multiple, intersecting identities and ascribed social positions (e.g., race, gender, sexual identity, class) along with associated power dynamics, as people are at the same time members of many different social groups and have unique experiences with privilege and disadvantage because of those intersections" (Rosenthal, 2016, p. 475).

Each individual has a multitude of diverse identities; some are visible and some are not readily identifiable. Each of the identities intersects with the other identities. The multiple intersections can serve to provide for further oppression and marginalization or further power and privilege, and/or they could mitigate one another, providing some facets of privilege and others of oppression. For example, an African American college professor who is a heterosexual woman with a doctoral degree is often oppressed and marginalized because of her race and gender; however, as a highly educated academic who is not gay, she experiences power and privilege, particularly in the academic classroom setting as the course professor. Another example is a female student who has experienced poverty on and off throughout her life cycle and identifies as biracial and gay; she may experience multiple identities that compound her oppression and marginalization (i.e., female, poor, gay, biracial). The concept of intersectionality provides a useful framework for healthcare professionals, as it helps them to understand the complexity of patients' diverse identities. Further, it provides a structure for understanding the multitude of factors that may cause a patient to be oppressed and/or privileged within the context of American society. In this same manner, it is important to recognize that culture is best described as fluid and subjective, as will be discussed in greater detail with respect to providing patient care with cultural humility.

Race, ethnicity, and immigration

The United States (US) is a nation of immigrants. The racial, ethnic, and immigrant diversity within American society is often cited as one of its greatest strengths. However, it has also been a challenge for America and for Americans in terms of fully accepting and embracing the broad array of immigrant groups that have become American. Historically, every new immigrant group has experienced various degrees of prejudicial and discriminatory treatment and exclusion from mainstream society. However, the experience of many European (e.g., Irish, Italian, German) immigrants was one of initial discrimination followed by swift acculturation and assimilation, likely aided by the physical appearance and language similarities to those of earlier settlers. Asian and Latina/o immigrants have experienced prejudicial treatment, possibly because of readily identifiable physical and language differences. Historical evidence of mistreatment is well documented, with perhaps one of the most egregious examples being the internment of Japanese Americans during World War II (Nagata et al., 2015).

Although Americans often think of the journey of voluntary immigration of the many ethnic groups that come to America to build a "better" life, the legacy of the forced immigration of African American slaves is often overlooked. African Americans endured 250 years of enslavement followed by 60 years of a status of "separate but equal" as well as continuing racist practices in education, housing, health, and criminal justice system. The systemic and continuous oppression of African Americans is a direct legacy of this forced immigration and has resulted in enduring educational, health, and wealth disparities (Bunch, 2016).

"New" immigrants from Afghanistan, Haiti, and other war-torn or environmentally impacted countries are experiencing prejudicial treatment in society and healthcare. The economic and social burden
of caring for these immigrants, in addition to the typical flow of immigrant populations, has aroused discriminatory attitudes in society and even in healthcare professionals that may already be stressed by COVID patient care.

Healthcare professionals' understanding of the differential treatment of current and past immigrant groups based upon ethnic, racial, religious, and linguistic background is paramount to their understanding of their patients. The way in which individuals and groups are treated from a sociopolitical (macro) level and from a daily individual interactional level (micro) necessarily affects their views and understanding of the world in which they live. From a person in environment perspective, individuals act upon the environment and the environment acts and reacts to the individual. Thus, while individuals help shape the environment around them, the environment also shapes the individual (Hutchison, 2021).

A demographic breakdown of the diversity in the US is provided in Tables 1 and 2. This breakdown may help healthcare professionals better conceptualize the potential diversity of experiences among their patients.

Demographics

The US has more immigrants than any other country in the world. Currently, more than 40 million people living in the US were born in another country. This figure represents one-fifth of the world's immigrants. Nearly every country in the world is represented among US immigrants (Pew Research Center, 2020b).

In 2018, there were a record 44.8 million immigrants living in the US. This figure represents 13.7% of the nation's population. Since 1965, the number of immigrants living in the US has more than quadrupled. Since 1970, the number of immigrants has nearly tripled (Pew Research Center, 2020a). Table 1 provides a breakdown of the US foreign-born population by national origin.

Table 1: Foreign-Born Population by Place of Birth 2018

Region	Number of People	Percentage
Mexico	11,182,111	25%
East and Southeast Asia	8,648,525	19.3%
Europe	4,848,270	10.8%
Caribbean	4,463,891	10%
South America	3,304,380	7.4%
Central America	3,590,330	8%
South Asia	3,668	8.2%
Sub-Saharan Africa	2,032,470	4.5%
Middle East-North Africa	1,784,898	4%
Canada and Other North America	827,093	1.8%
Oceania	246,371	0.6%
Central Asia	131,854	0.3%
Total	44,760,622	100%

(Based on data from the Pew Research Center [2020a]).

Tables 2-4 provides a breakdown of the US population by race.

Evidence-based practice! Data show that the population varies significantly by place of birth and race. Healthcare professionals must be aware of the populations they serve to practice cultural humility.

Table 2: Population by Race Self-Identification 2018		
Race	Number of People	Percentage
White	236,102,692	72.2%
Black or African American	41,683,829	12.7%
Asian	18,449,856	5.6%
Some Other Race	16,273,008	5%
Two or More Races	11,224,731	3.4%
Native American Indian and Alaska Native	2,826,336	0.9%
Native Hawaiian and other Pacific Islander	606,987	0.2%
(Pew Research Center, 2020a)		

Table 3: Population by Race Self-Identification US Born		
Race	Number of People	Percentage
White	215,726,882	76.4%
Black or African American	37,413,425	13.2%
Two or More Races	10,169,825	3.6%
Some Other Race	9,655,701	3.4%
Asian	2,627,659	2.2%
Native American Indian and Alaska Native	2,627,659	0.9%
Native Hawaiian and other Pacific Islander	460,543	0.2%
(Pew Research Center, 2020a)		

Table 4: Population by Race Self-Identification Foreign Born		
Race	Number of People	Percentage
White	20,375,810	45.5%
Asian	12,097,155	27%
Some Other Race	6,617,226	14.8%
Black or African American	4,270,404	9.5%
Native American Indian and Alaska Native	198,677	0.4%
Native Hawaiian and Other Pacific Islander	146,444	0.3%
Two or More Races	460,543	0.2%
(Pew Research Center, 2020a)		

Self-Assessment Quiz Question #2

In 2018, from which country/region did the highest number of foreign-born people residing in the US come from by place of birth?

a. South America.
b. East and Southeast Asia.
c. Mexico.
d. Sub-Saharan Africa.

Healthcare professionals must be careful not to make sweeping generalizations regarding characteristics or needs of any population. Further, patients are influenced by a variety of factors including level of acculturation (to be discussed later), immigration experience, experiences with discrimination, and ability to speak English. Therefore, it is imperative for healthcare professionals to ask patients about their personal experiences and important events in their lives. Some cultural generalizations may help clinicians increase their knowledge of specific cultures and enhance their understanding of a portion of patients' differing experiences. However, this is not intended to shift the healthcare professionals focus away from developing a better understanding of the dynamics of race, immigration, and other facets of diversity within the current social, economic, and political environment of the United States. Healthcare professionals are better prepared to both understand and help their patients if they are able to understand the cultural climate in which their diverse patients live and that climate's role in accommodating or marginalizing them. Moreover, healthcare professionals will provide better care for their patients if they develop a better understanding of how they personally are accommodated and marginalized by American culture. Race, ethnicity, and immigration status are only a few of the facets of diversity that affect patients. Other facets of diversity include socioeconomic status, disability, sexual orientation, religion, and gender identification. These facets of diversity can serve as dimensions that marginalize and/or oppress patients as well.

Poverty

Poverty is often a consequence of immigrants who have fled war zones, disaster areas, and regions of extreme high unemployment. The official poverty rate in 2020 was 11.4%, up 1% from 2019. This is the first increase in poverty after five consecutive annual declines. In 2020, there were 37.2 million people in poverty, about 3.3 million more than in 2019 (U.S. Census Bureau, 2020).

Evidence-based practice! Research shows that the poverty rate in the US is increasing. Healthcare professionals must be aware of data relating to poverty and work to decrease the growing problem of poverty.

Key points of the 2020 income and poverty in the US include the following (U.S. Census Bureau, 2020):

- Between 2019 and 2020, the poverty rate increased for non-Hispanic Whites and Hispanics. Among non-Hispanic Whites, 8.2% were in poverty in 2020, while Hispanics had a poverty rate of 17.0%. Among the major racial groups examined in this report, Blacks had the highest poverty rate (19.5%) but did not

experience a significant change from 2019. The poverty rate for Asians (8.1%) in 2020 was not statistically different from 2019.
- Poverty rates for people under the age of 18 increased from 14.4% in 2019 to 16.1% in 2020. Poverty rates also increased for people aged 18 to 64 from 9.4% in 2019 to 10.4% in 2020. The poverty rate for people aged 65 and older was 9.0% in 2020, not statistically different from 2019.
- Between 2019 and 2020, poverty rates increased for married-couple families and families with a female householder. The poverty rate for married-couple families increased from 4.0% in 2019 to 4.7% in 2020. For families with a female householder, the poverty rate increased from 22.2% to 23.4%. The poverty rate for families with a male householder was 11.4% in 2020, not statistically different from 2019.

Income data from this report include the following information (U.S. Census Bureau, 2020):
- Median household income was $67,521 in 2020, a decrease of 2.9% from the 2019 median of $69,560. This is the first statistically significant decline in median household income since 2011.
- The 2020 real median incomes of family households and nonfamily households decreased 3.2% and 3.1% from their respective 2019 estimates.
- The 2020 real median household incomes of non-Hispanic Whites, Asians, and Hispanics decreased from their 2019 medians, while the changes for Black households were not statistically different.
- In 2020, real median household incomes decreased 3.2% in the Midwest and 2.3% in the South and the West from their 2019 medians. The change for the Northeast was not statistically significant.

Women in Poverty
More women than men are living in poverty in the US. Men who have migrated for employment or to avoid conscripted military work often have left women behind. Migrating across hundreds of miles and difficult terrain is not feasible for women and children. Basic information about women in poverty includes the following (Bleiweis et al., 2020):
- Of the 38.1 million people living in poverty in 2018, 56%, or 21.4 million, were women.
- Nearly 10 million women live in deep poverty defined as falling below 50% of the federal poverty line.
- The highest rates of poverty are experienced by Native American Indian or Alaska Native (AIAN) women, Black women, and Latinas. About one in four AIAN women live in poverty. This is the highest rate of poverty among women or men of any racial or ethnic group.
- Unmarried mothers have higher rates of poverty then married women, with or without children, and unmarried women without children. Nearly 25% of unmarried mothers live below the poverty line.
- In 2018, 11.9 million children under the age of 18 lived in poverty. This accounts for 31.1% of those living in poverty.
- Poverty rates for women and men are almost even throughout childhood. However, the gap grows significantly for women ages 18 to 44 (during prime childbearing years) and again for women age 75 and older.
- Women with disabilities are more likely to live in poverty than both men with disabilities and persons without disabilities. Women with disabilities have a poverty rate of 22.9%, compared to 17.9% for men with disabilities and 11.4% for women without disabilities.
- LGBTQ women experience higher rates of poverty than cisgender (sense of personal identity and gender correspond with their birth sex) straight women and men because of the intersections of discrimination based on gender, sexual orientation, and gender identity or expression.

Reasons why women live in poverty

The impact of sexism and racism on society limit the employment opportunities available to women. Some of the causes of poverty in women include the following issues.

Wage Gap
Based on 2018 data, women working full-time, year-round earn on average 82 cents for every dollar earned by their male counterparts. This gap continues throughout the lifespan, leaving women with fewer resources and savings than men (Bleiweis et al., 2020).

Occupational Segregation into Low-Paying Jobs
Women are disproportionately represented in certain occupations, especially low-paying jobs. This is due, in part, to the perception of gender roles that assume women's work is low skilled and undervalued. This is especially true for women of color (Bleiweis et al., 2020).

Lack of Work-Family Policies
Issues such as insufficient paid family and medical leave and earned paid sick leave impact a woman's ability to manage work and caregiving. Childcare is expensive and sometimes hard to access. These issues further compound problems associated with work-family challenges. The coronavirus has exacerbated the caregiving burden on women because of essential school and childcare provider closures, which contributes to higher job loss among women (Bleiweis et al., 2020).

Disability
Disability may cause, as well as be a consequence of; poverty. People with disabilities must deal with barriers to employment as well as lower earnings. Only 16.4% of women who have disabilities were employed in 2018, compared with 60.2% without a disability (Bleiweis et al., 2020).

Domestic Violence
In the US, domestic violence is the cause of women's losing an average of eight million days of paid work per year. The Violence Against Women Act (VAWA) has led to lowered rates of gender-based violence in the US thanks to its programs and services. Unfortunately, the programs and services of the VAWA are not able to meet ongoing needs of domestic violence survivors without more funding and expansion of resources (Bleiweis et al., 2020).

Self-Assessment Quiz Question #3

Which of the following persons is most likely to live in poverty?

a. A woman who self-identifies as Alaska Native.
b. A man who is 45 years of age.
c. A married man with two children.
d. An unmarried woman without children.

Disability

Physical, intellectual, mental health, and other long-term disabilities constitute another facet of diversity within the United States. According to the Centers for Disease Control and Prevention (CDC; 2020), 61 million adults (26% of adults) in the US live with a disability.

According to the Equal Employment Opportunity Commission's (EEOC; 2021) Enforcement and Litigation Statistics and Agency Financial Report for Fiscal Year (FY) 2020, retaliation was the most frequently alleged discriminatory claim, accounting for 55.8% of all charges. Disability (36.1%) was the next most alleged category of discrimination, followed by race and sex. The percentage of each category decreased or remained stable compared to FY 2019 except for claims of retaliation, disability, color, and genetic information (EEOC, 2021).

Table 5 shows the percentage of adults with specific categories of disability in the US.

Table 5: Percentage of Adults with Functional Disability Types in the US		
Functional Disability	Description	Percentage
Mobility	Serious difficulty walking or climbing stairs.	13.7%.
Cognition	Serious difficulty concentrating, remembering, or making decisions.	10.8%.
Independent Living	Difficulty doing errands alone.	6.8%.
Hearing	Deafness or serious difficulty hearing.	5.9%.
Vision	Blindness or serious difficulty seeing.	4.6%.
Self-Care	Difficulty bathing or dressing.	3.7%.
(CDC, 2020)		

The CDC (2020) points out that:

- Two in five adults age 65 years of age and older have a disability.
- One in four women have a disability.
- Two in five non-Hispanic, Native American Indians/Alaska Natives have a disability.

Evidence-based practice! Research shows that adults living with disabilities are more likely to smoke, have obesity, have heart disease, and/or diabetes (CDC, 2020). Healthcare professionals must be alert to the diseases linked to disability. These diseases can compound the challenges that people with disabilities face.

People with disabilities face several barriers to accessing healthcare. These include the following (CDC, 2020):

- One in three persons does not have a primary healthcare provider. (Age group: 18-44 years.)
- One in three people has an unmet healthcare need because of cost in the past year. (Age group: 18-44 years.)
- One in four people did not have a routine check-up in the past year. (Age group: 45-64 years.)

Disability often compounds issues of poverty and access that can lead to an array of health consequences such as substance abuse, domestic violence, malnutrition, and even chronic mental health conditions.

Lesbian, gay, bisexual, transgender, queer/questioning population (LGBTQ)

The LGBTQ population is another historically oppressed group in the US. Until the 2015 Supreme Court decision legalizing same-sex marriage, LGBTQ individuals were not able to marry in most states.

There are more than 5.5 million LGBTQ individuals living in the US. The LGBT community face barriers to fair and equal access to employment, housing, healthcare, and public accommodation. There are several nondiscrimination laws on federal, state, and local levels that protect people from discrimination based on such factors as age, sex, and national origin. However, until 2020, federal law did not protect individuals from discrimination based on sexual orientation or gender identity (Roebig, 2020).

The Center for American Progress conducted a national public opinion study on the state of the LGBTQ community in 2020. The survey included interviews with 1,528 self-identified LGBTQ adults ages
18 and older. The project was funded and operated by the National Opinion Research Center (NORC) at the University of Chicago (Gruberg et al., 2020).

Major findings from the survey include the following (Gruberg et al., 2020):

- More than one in three LGBTQ Americans faced discrimination of some kind in the past year.
- More than three in five transgender Americans faced discrimination of some kind in the past year.
- Discrimination adversely impacted the mental and economic well-being of many LGBTQ Americans, including one in two participants who reported moderate or significant negative psychological impacts.
- More than half of LGBTQ Americans reported hiding a personal relationship to avoid experiencing discrimination.
- An estimated 3 in 10 LGBT Americans faced difficulties accessing necessary medical care because of cost issues.
- Fifteen percent of LGBTQ Americans reported postponing or avoiding medical treatment because of discrimination.
- Transgender individuals faced unique obstacles to accessing healthcare, including one in three who had to teach their physicians about transgender people.
- LGBTQ Americans may have also experienced significant mental health issues that are related to the COVID-19 pandemic.

Self-Assessment Quiz Question #4

All the following statements are accurate EXCEPT:

a. In the US 61 million adults live with a disability.
b. The type of functional disability that has the highest percentage is that of cognition.
c. More than half of LGBTQ Americans report hiding a personal relationship.
d. Transgender individuals face unique obstacles to accessing healthcare.

The complexity of individual diversity is inclusive of not just of racial and ethnic identity but also of variables such as socioeconomic class, disability, and LGBTQ status. While these facets of diversity are not exhaustive, they do represent some important categories of diversity. Healthcare professionals must consider the unique array of diverse identities that are represented within each individual encountered in each therapeutic relationship. The complexity embodied within each patient affects the way that the patient understands and views the healthcare professional and the professional relationship, just as the complexity of the healthcare provider's diversity dimensions affects the way that the healthcare professional understands and views each patient. It is impossible to provide information that allows healthcare professionals to gain knowledge about categories of people and how they behave or view the world, because not only is the variation within individual ethnicities and races endless, but the variation within each individual also is endless. Instead, healthcare professionals should aim to understand the societal landscape that privileges and oppresses individuals. The experiences of oppression experienced by various diverse groups are likely to provide them with a unique perspective on both the larger society and on the relationship with healthcare professionals.

OPPRESSION, PRIVILEGE, AND MARGINALIZATION

Understanding the concepts of oppression, privilege, and marginalization is essential for practicing with cultural humility. There are various aspects of individual identities that oppress or privilege people and their marginalization or empowerment.

Oppression can be defined as "unjust or cruel exercise of authority or power" (Merriam-Webster, 2021). A person or group that knowingly or unknowingly abuses a specific group. Oppression is a pervasive system. It has its foundation in history and is maintained via individual and institutional systematic discrimination, personal bias, bigotry, and social prejudice. Oppression leads to a condition of privilege for the person or the group that is the oppressor(s). National Conference for Community and Justice (NCCJ; 2021).

Privilege is a central concept within the healthcare professions. The concept of White privilege and male privilege was clearly articulated and widely disseminated through McIntosh's work in the 1980s. McIntosh articulated White male privilege as "an invisible package of unearned assets which he can count on cashing in each day, but about which he was 'meant' to remain oblivious. White privilege is like an invisible weightless knapsack of special provisions, assurance, tools, maps, guides, codebooks, passports, visas, clothes, compass, emergency gear, and blank checks" (McIntosh, 1998, p. 1). Privileging is "a process where chances or odds of being offered an opportunity are altered or skewed to the advantage of members of certain groups" (Minarik, 2017, p. 55). Essentially, privilege functions by providing some groups of individuals (e.g., White, male, heterosexual, abled, middle class) with preferred treatment in the form of special opportunities and advantages, while withholding that preference from other individuals (e.g., African American, female, LGBTQ, disabled). Privilege can include many advantages including being given the benefit of the doubt and feeling a sense of belongingness (Minarik, 2017). Individuals who are not privileged experience the opposite – such as being an automatic suspect or having to prove belonging (Minarik, 2017). Privilege is not a guarantee of success for those groups who receive it; however, it is an advantage that other groups do not receive and allows for opportunities that others are denied (Minarik, 2017). A final key aspect regarding privilege is that it is not necessarily visible to those who receive it. The invisibility of privilege is the key component that allows it to continue. More simply, when those who receive privilege do not recognize it, they are unable to take actions to change it. Once people become aware of privilege, they choose to use the benefits of privilege to advocate for marginalized populations.

Self-Assessment Quiz Question #5

When discussing oppression and privilege, healthcare professionals should know that:

a. Privilege is the commission of an unjust or cruel exercise of authority or power.
b. Privilege is a guarantee of success for groups receiving it.
c. Oppression's foundation is in the "me too" movement.
d. Oppression leads to a condition of privilege for the person or the group that is the oppressor(s).

Marginalization is an important concept in the delivery of patient care. Marginalization is the "act of placing a person or group in positions of lesser importance, influence, or power" (Dictionary.com., 2021). Examples of groups that have been, and are being, marginalized include ethnic and racial minorities, immigrants, the LGBTQ population, persons who are disabled, and the economically disadvantaged.

Some experts have identified the following three themes of marginalization (Baah et al., 2019):

1. Creation of Margins: Margins act as barriers and connections between a person and the environment. Margins construct physical, emotional, and psychological boundaries that people experience during interactions with society. Enforcement and maintenance of boundaries divide the political and socioeconomic resources in an uneven fashion. This also facilitates the unbalanced distribution of critical resources such as healthcare (Baah et al., 2019). This illustrates the concept of social determinants of health (SDH), which is defined as "the circumstances in which people are born, live, work and age and the systems put in place to deal with illness" (World Health Organization [WHO], 2010).
2. Living between Cultures: Living between cultures is another factor that links marginalization to SDH. Although the boundary or margin separates the dominant and peripheralized group, incomplete integration leads to a person or group that lives between cultures. Incomplete integration creates a situation where a person or group relinquishes characteristics of the marginalized group in order to bond with the dominant society, but is unable to do so. Examples of living between cultures are the ways of life of most immigrants, migrant farm workers, and other vulnerable groups. People living between cultures tend to live in areas characterized by limited employment and educational opportunities (Baah et al., 2019).
3. Creation of Vulnerabilities: Creation of vulnerabilities are created by the cumulative impact of the creation margins and living between cultures. Vulnerability is defined as a state of being exposed to and unprotected from health-damaging environments (Baah et al., 2019.

Marginalized groups often do not receive the same access to societal resources such as high-quality education, healthcare, housing, or equal access to voting as those groups that are not marginalized. The marginalization of oppressed groups prevents them from having a voice and helps to sustain the status quo in the United States in which White, economically well-off, and able-bodied individuals control access to social, economic, and political power.

Healthcare Professional Consideration: Healthcare professionals should recognize the power imbalances that result from oppression, privilege, and marginalization and work to correct the imbalances within the delivery of healthcare services and within the broader institutional and societal context.

Self-Assessment Quiz Question #6

When discussing themes related to marginalization, the concept of being exposed to and unprotected from health-damaging environments is referred to as:

a. Creation of margins.
b. Living between cultures.
c. Vulnerability.
d. Boundaries.

The concept of cultural humility was first discussed in the medical world to better understand and address health inequities and disparities (Tervalon & Murray-García, 1998). The concept has evolved to include ideas related to the creation of a broader and more inclusive society. Unlike the concepts of cultural competency and multicultural competency, which focus on gaining knowledge about cultural groups differing from the individual's own with the hopes of better understanding those cultures and thus better meeting the needs of different groups who enter counseling, cultural humility focuses on the cultural context within America that marginalizes and oppresses some groups of people, while privileging and empowering other groups of people (Foronda et al., 2016).

Attending to diversity

Critical Thinking Exercise

Trinh, a 17-year-old first-generation American of Hmong decent, is graduating first in her high school class. Her school counselor has encouraged her to apply to top-level colleges, several of which are hours from home. When Trinh asks about some nearby colleges, the counselor simply tells her that they are "well below her abilities," even though one is highly regarded. She is accepted by the top-level colleges to which she applied, including two Ivy League schools. Despite generous financial aid packages, Trinh does not accept offers from any of these schools. Past the deadline to apply to the local 4-year colleges, Trinh decides to go to the local community college and live at home. Her counselor tries to persuade Trinh to reconsider one of the Ivy League schools. Trinh tells the counselor that she needs to stay home to help care for younger siblings and translate for her parents during doctors' visits. The counselor engages Trinh in a role play to help her tell her parents that she needs to make her own decisions and go away to college.

Although school counselors do want their students to succeed, what underlying values might have clouded the counselor's judgment in working with Trinh? Trinh had given the counselor signals that she was not ready to move hours away when she asked about local colleges. Perhaps the counselor, working from a belief that individualism is preferred, ignored these clues, hoping not to play into Trinh's "separation anxiety." If the counselor had viewed her client as being both Trinh and her family, rather than only a young woman needing to be more independent, she could have worked with the family to make a decision that addressed both Trinh's needs and those of her family. By ignoring Trinh's cultural background and her sense of responsibility to the family, the counselor could not help in an informed way.

Given the vast diversity within the United States, both healthcare professionals and counselors must develop cultural humility as they work with individuals whose life experiences vary in myriad ways based on many intersecting dimensions of diversity. A primary component of cultural humility is self-awareness. As a healthcare professional, completely exploring one's own identity is of extreme importance. It is through knowing and understanding oneself that counselors and healthcare professionals can uncover their beliefs, values, and, moreover, their implicit biases.

Implicit bias is defined as an unconscious and unintentional bias (van Nunspeet et al., 2015). Individuals may not be aware of their implicit biases (Byrne & Tanesini, 2015). These biases are the result of combinations of factors including an individual's early experiences and learned cultural biases. Thus, ongoing critical self-reflection that understands the existence of implicit biases within everyone is necessary. Repeated and evolving processes of self-reflection make healthcare professionals' implicit biases explicit and, therefore, subject to examination and change (Byrne & Tanesini, 2015). In addition to understanding their own implicit biases, healthcare professionals, especially those from dominant societal groups (e.g., White, heterosexual, male), need to explore their own racial, ethnic, sexual, and class identity. Individuals from dominant cultural paradigms often consider themselves without racial, ethnic, sexual, or class identity as they have privilege; their identities are considered the norm. However, without deep exploration of intersecting aspects of personal diversity, it is difficult to understand oneself and where biases might insert themselves into healthcare professional relationships (Fisher-Borne et al., 2015).

Self-reflection and self-critique

Self-reflection and self-critique are ongoing, lifelong processes that allow healthcare professionals to continually refine their understanding of themselves and their actions and reactions within counseling contexts and to continually broaden and deepen their cultural understanding through introspection (Foronda et al., 2016). Through ongoing self-reflection and critique, the healthcare professional develops a better understanding of the dynamics within and outside the healthcare arena and of the ways these dynamics affect the patient's life, the healthcare professional's life, and the interactions between healthcare professional and patient.

Self-reflection is defined as deliberately paying attention to one's own thoughts, emotions, decisions, and behaviors. It is important for healthcare professionals to be able to self-reflect in "real time" as they deal with the variety of situations encountered in an ever-changing healthcare environment (Wignall, 2019).

Self-critique is the process of critically examining oneself to continually refine their understanding of themselves and their actions and reactions and to continually broaden and deepen their cultural understanding through introspection. Self-reflection and self-critique are best incorporated into practice on a reflexive basis. That is, the ongoing process of self-reflection should result in an automatic process or reflection as an integral part of practice. (Foronda et al., 2016).

Respectful partnerships

Developing respectful partnerships is key to providing healthcare services with cultural humility and, more generally, to developing a relationship within the counseling setting that allows work to begin and to continue in a productive fashion. Respectful partnerships include discussing and addressing such difficult topics and issues as race, socioeconomic class, gender, sexual identity, and disability. These discussions are uncomfortable for many; they bring up feelings, often passionate, associated with "isms," group identification, prejudice, quotas, and affirmative action. Yet these differences between healthcare professional and patient are a presence in the room and, when ignored, have the potential to interfere with an honest and open exchange (Minarik, 2017).

Healthcare professionals often attempt to take the emphasis off race, class, gender, and other areas of difference by denying the effect these aspects of diversity have on patients (e.g., "The only race I know is the human race"), or by trying to show that they understand the patient's experience because they, too, are a member of an oppressed group. For example, the African American patient may not feel that the healthcare professional, as a bisexual Jewish woman, understands subtle racial insults from personal experiences. Some healthcare professionals

imply that because they personally do not discriminate against oppressed groups, no personal or societal problems exist associated with race, class, LGBTQ status, or disability; this attitude negates the experience the patients may have in the larger society, where they experience various degrees of marginalization based on their intersecting identities (Minarik, 2017).

Respectful partnerships are developed when the healthcare professional facilitates a dialogue that illustrates an understanding of and attends to the complex dynamics related to privilege, oppression, and marginalization present within the patient/healthcare professional relationship and embedded within the larger society. The healthcare professional levels the playing field by conveying a respect for the patient and the patient's lived reality while inviting the patient to enter an equal partnership with the healthcare professional.

Healthcare Professional Consideration: The development of respectful partnerships is ongoing and acknowledges that the healthcare professional does not know what the patient's identity, life, or struggles look like but is eager to learn from the patient. Further, healthcare professionals who are developing respectful partnerships recognize that they may make mistakes and are open to patient feedback regarding those mistakes.

Self-Assessment Quiz Question #7

All the following statements concerning self-reflection, self-critique, and respectful partnerships are true EXCEPT:

a. Discussing and addressing topics and issues such as race and sexual identify may be uncomfortable for many people.
b. Healthcare professionals seldom attempt to take emphasis off race, gender, and other areas of differences.
c. Self-reflection and self-critique are ongoing, lifelong processes.
d. Self-reflection should result in an automatic process as an integral part of practice.

Lifelong learning

The commitment to lifelong learning within the ethical standards requires healthcare professionals to participate in activities that keep them current on issues and interventions within healthcare and that allow them to provide patients with the most appropriate care and service. Lifelong learning in the context of cultural humility emphasizes the importance of current issues inclusive of a multicultural perspective that encompass aspects of critical self-reflection and advocacy involving continued growth and learning. According to Fisher-Borne and colleagues (2015), "Cultural humility considers the fluidity and subjectivity of culture and challenges both individuals and institutions to address inequalities.

Cultural humility requires self-reflection and taking risks, discovering new information, and using patients and others as resources (Obiakor & Algozzine, 2016). Culturally humble learners understand that they will both make mistakes and learn from those mistakes because, as healthcare professionals, they are in a constant state of becoming. Lifelong learning allows the healthcare professional to integrate shifting paradigms and embark on continual reflection and reeducation regarding dominant perspectives on marginalized populations and communities (Obiakor & Algozzine, 2016). Finally, it requires that healthcare professionals separate themselves from thinking about patients from a deficit perspective and instead think of patients as fellow humans with rich intellectual, cultural, ethnic, and class backgrounds and with a myriad of strengths (Obiakor & Algozzine, 2016). Recognizing and reflecting on one's own possible biases, religious values, and family values may help to limit the influence of those biases on their patient interactions.

White identity

White identity theory was first developed by Helms in the 1980s and 1990s as a tool for White healthcare professionals to "create meaning about their identities as Caucasians, particularly in terms of how they think about, respond to, react to and interact with patients from different racial/ethnic groups" (Chung & Bemak, 2012, p. 67). In other words, the theory's formation was based on the idea that White people are so immersed in the dominant culture that they are unaware of the influence of the dominant culture's ethnocentric images and ideals. Being White makes it easier to assimilate into the dominant culture and to partake in unearned privileges many White people enjoy but do not acknowledge. Most White people perceive themselves as unbiased, but such self-perception may truly impede one from taking responsibility for one's own prejudices (Sue & Sue, 2016). White healthcare professionals have a special responsibility to understand their own privileges, biases, racism, and discrimination so that they may develop a positive relationship within counseling sessions.

Healthcare Professional Consideration: National surveys do not have a historical track record of asking White people meaningful questions about their racial identity (Schildkraut, 2017). Healthcare professionals should promote research that includes questions about racial identity.

Self-Assessment Quiz Question #8

When exploring one's own beliefs about White identify, it is important to acknowledge that:

a. Most White people perceive themselves as biased.
b. White identity theory was first developed to discount the idea that White identity exists.
c. National surveys often ask White people questions about their racial identity.
d. Being White makes it easier to assimilate into the dominant culture.

Assessment and treatment

It is important for healthcare professionals to approach every individual patient with a cognizance of the possible various intersecting identities within the patient, but without a stereotype of the patient based on preconceived notions of these intersecting identities (e.g., race, ethnicity, LGBTQ status). Implementing the practice of cultural humility may flummox healthcare professionals as they approach patients in a clinical setting (Schildkraut, 2017).

The following example from Wyatt (n.d.) illuminates some key elements of providing patient care with cultural humility. An interracial couple, an African American father and a White mother, come into therapy because their child was kicked out of school for fighting and the father was called into child protective services for spanking his child. When they entered the office, the father was very angry and the mother was getting extremely upset, trying to calm him down. The White therapist suggested meeting with the father alone first. When he met with the father,

rather than trying to silence his rage, he joined with him by stating, "It sounds like you're furious with the situation that's happened; you're tired of it." The father was able to calm down at that point, as the White therapist was allowing him to be angry in his presence and was acknowledging that there might be a reason for anger. The therapist then asked the father if his disciplining method had anything to do with wanting to protect his child. The father responded that, yes, he was afraid his child, "a Black kid," was at risk of going to prison if he was fighting at school. The father did not want that for his child and was frightened. By providing room for the father to express his rage and his fear, the therapist was able to make the clinical session more meaningful.

Healthcare professionals who practice cultural humility also recognize that assessment tools and treatment protocols may not be appropriate for all patients. Historically, many therapeutic strategies employed in patient care were developed without empirically supported research with ethnic minorities (Sue & Sue, 2016). However, healthcare professionals should not rely solely on manualized treatment protocols to guide their interventions, as such an approach can fail to appreciate patients' unique experiences and the effect of differing social environments. Rather, when employing a research-based therapeutic practice, healthcare professionals should adapt the approach in accordance with the patients' values, experiences, and preferences while understanding the influence of the broader societal context (Jackson, 2015). Through facilitating a respectful partnership that allows patients to take the lead in narrating their experiences and in identifying personal treatment goals, healthcare professionals can create an environment that appreciates patients' perspectives. Table 6 outlines the important aspects of the multicultural perspective in clinical settings.

The considerations outlined in Table 6 require healthcare professionals to balance many different facets of patients and their lived experiences. It is especially important in treatment to adhere to these guidelines, as it sets up a therapeutic environment in which healthcare professional and patients are equal, while forcing healthcare professionals to consider the validity of various worldviews and the structural inequities that contribute to the problems and issues patients bring into therapeutic relationships.

Table 6: Multicultural Perspectives in Providing Healthcare

1. Provides the opportunity for two persons – from different cultural perspectives – to disagree without one being right and the other wrong.
2. Tolerates and encourages a diverse and complex perspective.
3. Allows for more than one answer to a problem and for more than one way to arrive at a solution.
4. Recognizes that a failure to understand or accept another worldview can have detrimental consequences.
5. Takes a broad view of culture by recognizing the following variables: ethnographic (ethnicity, race, nationality, religion, language usage, ability, LGBTQ status); demographic (age, gender, gender identity, place of residence); status (social, economic, educational factors); affiliations (formal memberships, informal networks).
6. Conceives of culture as complex when we count the hundreds or perhaps even thousands of culturally learned identities and affiliations that people assume at one time or another.
7. Conceives of culture as dynamic as one of such culturally learned identities replaces another in salience.
8. Uses methods and strategies and defines goals constituent with life expectations and values.
9. Views behaviors as meaningful when they are linked to culturally-learned expectations and values.
10. Acknowledges as significant within-group differences for any particular ethnic or nationality group.
11. Recognizes that no one style of counseling – theory of school – is appropriate for all populations and situations.
12. Recognizes the part that societal structures play in patient's lives.

Note. Adapted in part from Gonzale et al., 1994.

Self-Assessment Quiz Question #9

Multicultural perspectives in providing healthcare include all the following EXCEPT:

a. Provides opportunities for two persons from the same cultural perspective to disagree.
b. Takes a broad view of culture by recognizing variables.
c. Uses methods and strategies and defines goals constituent with life expectations.
d. Views behaviors as meaningful when they are linked to culturally learned values.

Healthcare professional roles

Culturally humble healthcare professionals need to work toward understanding themselves and their patients within the context of privilege, oppression, and marginalization. A healthcare professional's work engages patients as equal partners and addresses social inequalities and injustices on institutional and societal levels. The culturally humble healthcare professional sees their role in the provision of "therapeutic interventions" and addresses systems that serve to oppress marginalized communities to promote optimal well-being for patients, communities, and society. The healthcare professional can fulfill many roles. Because multicultural patient care is closely linked to the values of social justice, the need for a social justice orientation in patient care is apparent (Sue & Sue, 2016).

Social justice counseling is defined as "an active philosophy and approach aimed at producing conditions that allow for equal access and opportunity; reducing or eliminating disparities in education, health care, employment, and other areas that lower the quality of life for affected populations; encouraging the healthcare professional to consider micro, mezzo, and macro levels in the assessment, diagnosis, and treatment of patient and patient systems; and broadening the role of the helping professional to include not only caregiver/patient therapist but advocate, consultant, psycho-educator, change agent, community worker, and so on" (Sue & Sue, 2016, p. 134). The social justice perspective requires healthcare professionals to assess and intervene with a perspective that balances the individual patient and the system(s) in which the patient is experiencing difficulties (Sue & Sue, 2016).

The healthcare professional can act as advocate and actively speak with and, when necessary, for members of populations who are oppressed by the dominant society. These populations are confronted with institutional and societal oppression. Healthcare professionals can also be effective as "change agents" working to transform oppressive features of the institutional and societal environments. Rather than attributing patient problems to individual deficits, the healthcare professional works with the patient to identify external contributors to the problem and to remediate the consequences of oppression.

Further, critical self-reflection in the context of cultural humility includes analysis of power differentials and how those differentials may play out on both individual and institutional levels (Fisher-Borne et al., 2015). Practicing with cultural humility suggests that healthcare professionals go beyond the confines of their offices to address differences in power and privilege that affect patients in very tangible ways.

Healthcare professionals need to be self-aware and realize that patients react positively to healthcare professionals who display personal warmth, authenticity, credibility, and respect and who strive for human connectedness. Practicing with cultural humility provides the following:

> *A promising alternative to cultural competence … as it makes explicit the interaction between the institution and the individual and the presence of systemic power imbalances. It further calls upon practitioners to confront imbalances rather than just acknowledge they exist. Cultural humility challenges us to ask difficult questions instead of reducing our clients to a set of norms we have learned in a training or course about "difference." We believe that asking critical questions … challenge our own practice as well as our organizations and institutions and will provide a deeper well from which to approach individual and community change and effective long-term practice (Fisher-Borne et al., 2015, p. 177).*

Institutional and societal accountable: Social justice

Healthcare delivery takes place within and reflects the larger culture. Although healthcare delivery can certainly aid in the wellness of patients, it does not occur in a vacuum. Wellness cannot be achieved when social injustice is present.

Traditionally some healthcare professionals may consider issues of social justice outside the realm of their practice; however, if social justice is relegated to a select few, oppression will flourish and efforts to heal communities will be blocked. The healthcare professional practicing within a social justice framework would not locate the problem within the individual but would look to the environmental factors that contribute to the actions and reactions of the individual (Sue & Sue, 2016).

Social justice is the view that everyone deserves equal economic, political, and social rights and opportunities. Social justice depends on economic justice. Proponents of social justice explain that there must be fair and compassionate distribution of economic growth. Social justice requires that all persons be provided with access to what is good for the person and in associations with others. According to the principles of social justice, all people have a personal responsibility to work with others to design and continually perfect societal institutions for both personal and social development (San Diego Foundation, 2016).

Although there are variations among the definitions of social justice, there are three factors that are part of all definitions. These are (San Diego Foundation, 2016):

- Equal rights.
- Equal opportunity.
- Equal treatment.

In other words, social justice mandates equal rights and equal opportunities for everyone.

It is imperative that healthcare professionals ask themselves key questions that facilitate the acquisition of social justice. Examples of such questions include the following:

- How do my behaviors within patient interactions actively challenge any power imbalances and involve communities experiencing marginalization?
- How, as healthcare professionals, do we address inequalities?
- How am I extending my responsibility beyond individual patients?
- How am I advocating for policy and practice changes at institutional, community, state, and national levels?
- What institutional structures are in place that address inequalities?
- What training and professional development activities are offered at our institution or in our community that address inequalities?
- How can we engage our community to make sure its voice is heard in this work?

(Adapted and updated from Fisher-Borne et al., 2015, p. 176).

These types of questions can provide a starting point for healthcare professionals to address social injustices. Healthcare professionals can use their positions to advocate for changes in society to promote social justice. Working toward social justice, patients are empowered and can help create an environment in which equal rights, treatment, and opportunity are available to all.

Self-Assessment Quiz Question #10

The factors that are common to all definitions of social justice include:

a. White identity.
b. Equal opportunity.
c. Equal incomes.
d. Diversity in all groups.

DIFFERENCES BETWEEN MULTICULTURAL COMPETENCY AND CULTURAL HUMILITY

Cultural humility is a conceptual framework that was first developed and utilized in the field of medicine and nursing in the 1990s. Since that time, it has become more widely applied to all helping professions. The framework is intended to address some of the shortcomings within the cultural competency and multicultural counseling frameworks. The approach of cultural humility differs from the multicultural competency approach in that it recognizes that knowledge of different cultural backgrounds is not sufficient to develop an effective patient/healthcare professional relationship with each individual. The cultural competency and multicultural counseling frameworks are most often criticized for creating a model that serves to "other" ethnic, racial, and various minority groups (Carten, 2016, p. xlii) while not acknowledging "Whiteness" as an identity and as a culture. "Othering" is the term used for the "biased assumptions about populations viewed as 'the other' at various times in the country's history" as well as in the present (Carten, 2016, p. xlii).

Othering assumes that various oppressed and marginalized populations are different from the American "norm," commonly understood as a White, middle class, able-bodied, straight, male, and individually responsible for any difficulties they may experience. Multicultural patient care delivery and cultural competency frameworks commonly assume that the healthcare professional is White and that patients are the "other" and set out to describe what various racial and ethnic groups believe and how they act as a group. On the other hand, a cultural humility framework emphasizes self-understanding as primary to understanding others. To facilitate self-understanding, cultural humility encourages ongoing critical self-reflection, asking the healthcare professionals to delve into their cultural identity and its effect on the delivery of patient care. Cultural humility makes no assumption regarding the healthcare professional's identity and especially challenges White practitioners to explore and understand their "White identity" (Carten, 2016). Table 7 illustrates the differences between (multi)cultural competence and cultural humility frameworks.

Table 7: (Multi) Cultural Competence and Cultural Humility		
	(Multi) Cultural Competence	Cultural Humility
Perspectives on Culture	• Acknowledges layers of cultural identity. • Recognizes danger of stereotyping.	• Acknowledges layers of cultural identity. • Understands that working with cultural differences is an ongoing, lifelong process • Emphasizes understanding self as well as understanding patients..
Assumptions	• Assumes the problem is a lack of knowledge, awareness, and skills to work across lines of difference. • Individuals and organizations develop the values, knowledge, and skills to work across lines of difference.	• Assumes an understanding of self, communities, and colleagues is needed to understand patients. • Requires humility and a recognition and understanding of power imbalances within the patient-healthcare professionals' relationship and in society.
Components	• Knowledge. • Skills. • Values. • Behaviors.	• Ongoing critical self-reflection. • Lifelong learning. • Institutional accountability and change. • Addressing and challenging power imbalances.
Stakeholders	• Practitioner.	• Patient. • Practitioner. • Institution. • Larger community.
Critiques	• Suggests an end point. • Can lead to stereotyping. • Applied universally rather than based on a specific client's experience(s). • Issues of social justice not adequately addressed. • Focus on gaining knowledge about specific cultures.	• A "young concept". • Empirical data in early stages of development. • Conceptual framework still being developed.
Note. Adapted from Fisher-Borne, M., Cain, J. M., & Martin, S. L. (2015). From mastery to accountability: Cultural humility as an alternative to cultural competence. Social Work Education, 34, 165-181.		

Although the intent to understand the diversity within the United States is meant to be helpful to healthcare professionals, it often leads to strengthening the status quo (i.e., "White" as the norm and all other racial and ethnic groups as outside that norm). Because of the desire to describe various racial and ethnic norms, multicultural patient care delivery and cultural competency frameworks tend to overlook the diversity within ethnic and racial minority groups and within "White" groups (Carten, 2016; Fisher-Borne, 2015).

The multicultural counseling and cultural competency frameworks also tend to neglect the intersecting dimensions of diversity. By focusing on ethnic and racial groups, these models neglect the complexity of group and individual identity. Complex identities include a multitude of dimensions of diversity, such as race, ethnicity, socioeconomic class, LGBTQ status, dis/ability, religion, regionality (e.g., southern, northern, western, eastern regions of the United States), age, gender, religion, etc. These dimensions of diversity intersect in many ways. The intersectionality of a multitude of dimensions that are oppressed or marginalized identities within one individual may result in experiencing much discrimination (Rosenthal, 2016). On the other hand, the intersection of a multitude of dimensions that are privileged within one individual may result in experiencing much opportunity. Moreover, the intersectionality of dimensions of diversity results in an infinite number of individual identities that are difficult, if not impossible, to categorize (Rosenthal, 2016).

Multicultural counseling and cultural competency frameworks have been further criticized for focusing on having healthcare professionals gain knowledge regarding differing racial and ethnic groups and assuming that there is an end point in cultural training, where the healthcare professionals' competency is deemed competent (Fisher-Borne et al., 2015). However, culture is fluid and ever-changing, with a complex array of interacting dimensions. Thus, it is not possible to reach an end point and to be deemed competent.

The final major criticism of multicultural patient care delivery and cultural competency frameworks is that they do not present a social change/social justice perspective (Fisher-Borne et al., 2015). These frameworks assume that the lack of knowledge and understanding of oppressed and marginalized groups is commonly responsible for inadequate and/or ineffective healthcare delivery. The frameworks fail to address the power imbalances present in society and its institutions that are integral to many challenges and/or issues that patients bring to healthcare interactions. Cultural humility requires patient care professionals to recognize the power imbalances within the healthcare community and in society. Moreover, cultural humility demands that practitioners hold institutions accountable and asks that healthcare professionals work to right social injustices on community and national levels to achieve wellness for patients that can only be realized through working toward a more equitable society (Foronda et al., 2016).

It is important to note that the healthcare professions are committed to cultural competency and increasingly understand the need to adopt a cultural humility framework as well. Healthcare professions incorporate cultural competency and cultural humility within their ethical and educational guidelines for competent practice (APA, 2017; ASCA, 2016; NASW, 2021). The professions share some commonalities within their guidelines for culturally sensitive practice. There is a need to continually develop an understanding of the diversity of patients and to commit to lifelong learning.

Case study: James Choi

James Choi is a 25-year-old Korean American, a new college graduate who recently accepted a job as a fund-raiser at the Humane Society. He was adopted when he was 8 months old into a middle-class White family. He seeks therapy because he feels that he is not achieving as much as he would like with his career. James is feeling anxious and has some symptoms of depression. His family physician has prescribed an antidepressant and encourages James to participate in mental health therapy. He is seeing Denise, a clinical psychologist who works in a large mental health counseling practice. Denise is a 30-year-old White woman. She is a recent graduate who has learned a bit about Asian American culture in her graduate coursework. On James's first visit, Denise asks him what brings him to counseling. James explains that he is disappointed in himself for not achieving more in his career. He explains that he has been feeling anxious and depressed and identifies the antidepressant that he is taking. Denise nods in understanding and remembers that Asian American families often have high academic standards and family members have a difficult time seeking therapy, concerned about losing face. As a result, Denise compliments James on being brave enough to seek therapy. James seems confused by Denise's response but manages to say thank you. James then proceeds to tell Denise that his parents encouraged him to seek therapy, as they thought that he was showing signs of depression. Denise is surprised that an Asian family would encourage their son to seek counseling but knows that she may have been stereotyping based on his ethnicity. Denise continues with the questions, as she does want to know more about his feelings regarding not achieving as much as he would like in his career as well as his symptoms of anxiety and depression. She asks James why he is feeling that he is not achieving as much as he should be. James shrugs and says he thought he would be at a higher position after completing college. Denise knows that Asian Americans often expect high achievement from their children, so she asks James how his parents feel about his success thus far. James surprises her again when he says his parents are extremely proud of him and think he has landed a great first job. Denise is baffled and asks James to share more about his disappointment given his parents' support and his success at both graduating from college and getting a job so quickly. She remembers again to be careful not to stereotype. When the session concludes, she asks James to schedule another session so they can explore his concerns further. James says he will on his way out and thanks Denise for her help. Yet, he never returns to counseling.

Questions

1. What are some of the reasons James might not have pursued further therapy with Denise?
2. How could Denise have prepared differently for her session with James?
3. How might she have applied some of the facets of cultural humility in her counseling?
4. How do you think James thinks the healthcare professional perceives him? Is it helpful to the therapeutic relationship?

This case illustrates how unintentional stereotyping can hinder the development of a therapeutic relationship. Denise is aware that she may be stereotyping but is having difficulty changing her thinking about Asian Americans. James's experiences in life are vastly different from what Denise imagines they are, and thus he feels as if he is not being understood or helped by Denise. Denise might be helped by engaging in critical self-reflection after her session with James. She might ask herself what went wrong. She might further explore her stereotypical reaction to James and how that might have alienated him rather than engaged him in working with her. Denise might have had more success if she had questioned him more about his background and his family and had engaged him as an expert on his own life as she forged a respectful partnership with him. It seems as if Denise felt she had to be the expert and display cultural competency, which may have prevented her from being able to listen to James and discover the unique diversity in his life.

Case study: Linda Rogers

Linda Rogers is a 28-year-old White woman who has two children, ages seven and three. She and her fiancé live in a trailer park in a rural area. She comes into the county mental health clinic because she is experiencing headaches and dizziness and often has severe stomachaches. The clinic physician suggested Linda make an appointment because, upon examination, she could not find a physical reason for Linda's headaches and stomach problems. During the intake, Linda reports that she often skips meals or eats something from the vending machine at work for lunch; she also admits to smoking. Linda also reports that she typically feels fine and tries to limit her visits to the clinic. When Janine, the African American, upper-middle-class mental health nurse practitioner, asks Linda what she feels her stomachaches are caused by, Linda seems unsure and on the verge of tears. Janine compliments Linda for coming to therapy and asks her to discuss her problems more fully. Linda states that she has a lot of stress in her life as she has two minimum-wage jobs and two kids. She states that her fiancé is supportive, but he experiences a great deal of stress, too. Janine is empathetic and agrees that there is a lot of stress in Linda's life. Janine asks Linda what she does to reduce stress. Linda states that her breaks at work give her the opportunity to smoke and that smoking temporarily relieves her stress and her physical symptoms. Janine feels strongly that smoking is a bad habit, and although it might temporarily relieve stress, Linda should attempt healthy stress relief techniques. Linda nods in agreement but acknowledges it has been difficult to quit smoking. Janine asks what Linda likes to do in her free time. Linda states that she does not have much free time between work and her kids. Janine asks Linda if she would like information about a smoking-cessation class offered at the clinic to help her stop smoking. Linda nods and accepts the pamphlet Janine offers. They spend the rest of the session brainstorming about other ways to reduce the stress in Linda's life. Linda is engaged in the brainstorming and agrees to try to use her work breaks to walk off her stress. At the end of the session, Janine again affirms Linda, telling her she is glad that she came in and that it is wonderful she will begin smoking-cessation classes and use her work breaks to decrease her stress by taking a short walk.

Linda misses the next several sessions with Janine. She shows up for a session with Janine several months later. Janine greets Linda warmly and says she has missed her at her previously scheduled sessions. Janine then asks Linda about her stress and her headaches and stomachaches. Linda says she is still very stressed and continues to experience headaches and stomachaches. Janine gently asks whether she attended any smoking-cessation sessions. Linda states that she doesn't have the time or energy to attend the classes. Janine asks whether Linda has been walking during work breaks. Linda looks abashed but admits that she is still using breaks to smoke. Janine is a bit frustrated and asks Linda what she thinks they should work on in session today to reduce stress. Linda doesn't seem to know what to do, so Janine suggests they try other options to reduce stress. Linda agrees. The rest of the session is spent coming up with a detailed plan to reduce stress through breathing exercises and a plan to try to attend smoking-cessation sessions.

When Linda returns to counseling several weeks later, she again admits to not following through on Janine's suggestions. She is still stressed. Janine is frustrated at the lack of progress

but continues to try to help Linda with her stress through offering a variety of self-care options. Linda continues to agree to try a variety of techniques and agrees to continue to meet, but with little enthusiasm.

Questions

1. What cultural forces might have affected Linda and Janine's interactions?
2. How might Janine have explored Linda's stress more comprehensively?
3. How did the therapy techniques reflect a middle-class perspective?
4. If you were the nurse practitioner, what would you do? Why?

It is not surprising that Linda sought help from the clinic doctor first because her poverty likely afforded her little opportunity to seek therapy. Fortunately, the clinic she went to had counseling services available and Linda was able to meet with a therapist.

Although Janine is empathetic and caring, she fails to make headway with Linda's stress and is frustrated by Linda's lack of follow-through. Janine neglects to thoroughly explore the role that poverty plays, both in Linda's stress response and in her ability to pursue stress reduction in the way that someone with more resources might be able to. Linda does not have the luxury of time, and smoking provides her quick relief. Although Linda may want to stop smoking, it is unlikely that she has the time to devote to smoking-cessation classes. Janine might have wanted to work with Linda on some of the stressors in her life that require advocacy outside the office. For example, Linda's inadequate diet may be the result of not being able to afford enough food. Janine could have explored this with Linda and helped Linda access various governmental and nonprofit programs to help her obtain sufficient food. Although Linda agreed to continue to work with Janine, she may have done so because she does not feel that she had an option.

Conclusion

When working with patients from diverse backgrounds, healthcare professionals must be willing to continuously look at personal dimensions of diversity and at how those dimensions affect their worldview and their view of their patients. Thus, healthcare professionals enter the professional relationship with a solid base of self-knowledge and a continuous commitment to critical self-reflection. Healthcare professionals also enter into patient interactions with an open mind and curiosity regarding patient's lived experience. Healthcare professionals do not pretend to know or understand each patient's unique combination of facets of diversity and do not assume that the patient will behave or believe in any way based on those facets of diversity. In fact, the culturally humble healthcare professional "cultivate(s) openness to the other person by regulating one's natural tendency to view one's beliefs, values, and worldview as superior, indeed, the culturally humble healthcare professional strives to cultivate a growing awareness that one is inevitably limited in knowledge and understanding of patients' backgrounds" (Hook et al., 2016, p. 152).

This stance of openness and equality provides an environment for healthcare professionals to enter respectful and equitable partnerships with patients. Moreover, the culturally humble healthcare professional considers how the societal structures in the United States serve to oppress some individuals and groups while empowering other individuals and groups. Patients are affected by the inequality within the United States. They are affected by living in a society where racism, sexism, classism, homophobia, and discrimination based on a variety of other diverse identities, including disability and gender identity, are expressed in a multitude of ways; this discrimination obstructs access to resources and opportunities and impedes interpersonal relationships. The power imbalances within society and institutions and as experienced by patients require the culturally humble healthcare professional to take an active role in righting those imbalances. Cultural humility challenges healthcare professionals to ask difficult questions and encourages them not to reduce patients to a preconceived set of cultural norms that have been learned in trainings about diversity and difference (Foronda et al., 2016). Finally, the culturally humble healthcare professional will engage in lifelong learning that supports effective practice.

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Self-Assessment Answers and Rationales

1. The correct answer is B.
Rationale: Cultural humility is an ongoing process, which requires continual self-reflection and self-critique. Cultural humility is a prerequisite to cultural competency.

2. The correct answer is C.
Rationale: The highest number of foreign-born people came from Mexico. They represented 25% of the population of foreign-born people by country of birth residing in the US. There were 11,182,111 people belonging to this group.

3. The correct answer is A.
Rationale: The highest poverty rates are experienced by Native American Indians, Alaska Natives, Black women, and Latinas. About one in four Alaska Native women live in poverty.

4. The correct answer is B.
Rationale: The type of functional disability that has the highest percentage is mobility. The percentage of people with mobility disability is 13.7%.

5. The correct answer is D.
Rationale: Oppression is a pervasive system. It has its foundation in history and is maintained via individual and institutional systematic discrimination, personal bias, bigotry, and social prejudice. Oppression leads to a condition of privilege for the person or the group that is the oppressor(s).

6. The correct answer is C.
Rationale: Creation of vulnerabilities are created by the cumulative impact of the creation margins and living between cultures. Vulnerability is defined as a state of being exposed to and unprotected from health-damaging environments.

7. The correct answer is B.
Rationale: Healthcare professionals often attempt to take the emphasis off race, class, gender, and other areas of difference by denying the effect these aspects of diversity have on patients' (e.g., "The only race I know is the human race"), or by trying to show that they understand the patient's experience because they, too, are a member of an oppressed group.

8. The correct answer is D.
Rationale: Being White makes it easier to assimilate into the dominant culture and to partake in unearned privileges many White people enjoy but do not acknowledge.

9. The correct answer is A.
Rationale: Multicultural perspectives provide the opportunity for two persons – from different cultural perspectives – to disagree without one being right and the other wrong.

10. The correct answer is B.
Rationale: Although there are variations among the definitions of social justice, there are three factors that are part of all definitions. These are equal rights, equal opportunity, and equal treatment. In other words, social justice mandates equal rights and equal opportunities for all.

Course Code: ANCCAR03CH

Documentation in the Electronic Age for Nurses

3 Contact Hours

Release Date: November 11, 2021

Expiration Date: November 11, 2024

Faculty

Catherine N. Turner, MBA, BSN, RN-BC Early in her career, Catherine Turner, BSN, MBA, RN-BC recognized the value that technology could bring to patients, care teams, and healthcare organizations. As an advocate of maximizing technology to provide safer care, she has lent her passion and expertise to the implementation, development, and marketing of MEDITECH's Electronic Health Record (EHR). Ms. Turner is well-known as a leader in the nursing informatics community. She is the Director of MEDITECH's Nurse Informatics Program and spearheads the annual Nurse Conference. She is an active member and current co-chair of the HIMSS CNO-CNIO Vendor Roundtable Summit, served previously on the Corporate Advisory Board for the American Nurses Foundation, is a current member of the Healthcare Information Management System Society (HIMSS) and the American Nursing Informatics Association (ANIA), and represents MEDITECH's Nursing Informatics Program for the Alliance for Nursing Informatics (ANI). Ms. Turner has been a reviewer for a number of publications as well as a popular presenter at nationwide conferences and past content expert for AHIMA publications. She is a lecturer at the Northeastern University Bouvé College of Health Sciences Health Informatics Program and worked previously at the School of Nursing, having taught both programs in the classroom and online, as well as having taught and developed the course "Introduction to Health Informatics" at the University of Miami, FL for their Master's in Health Informatics Program.

Catherine N. Turner has disclosed that she has no significant financial or other conflicts of interest pertaining to this course.

Reviewer:

Jennifer Tucker, MA, RN, is a masters prepared nurse educator who graduated from Viterbo University in 2006 and St. Catherine's University in 2010. Currently she is serving as a telephone triage nurse for patients from age 1 day to 101 years. She also works in a Level 3 NICU in a large urban county hospital. She has a background in simulation education, holds a faculty position in a nursing program, and provides dialysis education and education leadership for a large rural health system.

Jennifer Tucker has disclosed that she has no significant financial or other conflicts of interest pertaining to this course.

Course overview

The purpose of this course is to identify various methodologies of electronic nursing documentation, explore dependency on standardized nomenclature to provide trending and analyzable data and outcomes for both the patient population and healthcare at large, as well as future innovations.

Learning objectives

Upon completion of this course, the learner should be able to:

- Describe the major advantages and disadvantages of performing the appropriate method of documentation based on data composition.
- Demonstrate how value-added documentation can result in incentive reimbursement as a by-product of electronic documentation.
- Realize benefits and best practices of using electronic nursing documentation while minimizing challenges.
- Discuss measures that protect privacy, confidentiality, security, and authenticity with the use of electronic documentation.
- Adopt future initiatives in electronic documentation to further facilitate quality, efficiency, and safety.

How to receive credit

- Read the entire course online or in print which requires a 3-hour commitment of time.
- Complete the self-assessment quiz questions which are at the end of the course or integrated throughout the course. These questions are NOT GRADED. The correct answer is shown after you answer the question. If the incorrect answer is selected, the rationale for the correct answer is provided. These questions help to affirm what you have learned from the course.
- Depending on your state requirements you will be asked to complete either:
  - An affirmation that you have completed the educational activity.
  - A mandatory test (a passing score of 70 percent is required). Test questions link content to learning objectives as a method to enhance individualized learning and material retention.
- If requested, provide required personal information and payment information.
- Complete the MANDATORY Course Evaluation.
- Print your Certificate of Completion.

CE Broker reporting

Colibri Healthcare, LLC, provider # 50-4007, reports course completion results within 1 business day to CE Broker. If you are licensed in Arkansas, District of Columbia, Florida, Georgia, Kentucky, Michigan, Mississippi, New Mexico, North Dakota, South Carolina, or West Virginia, your successful completion results will be automatically reported for you.

Accreditations and approvals

Colibri Healthcare, LLC is accredited as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation.

Individual state nursing approvals

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Activity director

Shirley Aycock, DNP, RN, Executive Director of Quality and Accreditation

Disclosures

Resolution of conflict of interest
In accordance with the ANCC Standards for Commercial Support for continuing education, Colibri Healthcare, LLC implemented mechanisms prior to the planning and implementation of the continuing education activity, to identify and resolve conflicts of interest for all individuals in a position to control content of the course activity.

Sponsorship/commercial support and non-endorsement
It is the policy of Colibri Healthcare, LLC not to accept commercial support. Furthermore, commercial interests are prohibited from distributing or providing access to this activity to learners.

Disclaimer

The information provided in this activity is for continuing education purposes only and is not meant to substitute for the independent medical judgment of a healthcare provider relative to diagnostic and treatment options of a specific patient's medical condition.

Course verification

All individuals involved have disclosed that they have no significant financial or other conflicts of interest pertaining to this course. Likewise, and in compliance with California Assembly Bill No. 241, every reasonable effort has been made to ensure that the content in this course is balanced and unbiased.

INTRODUCTION

Every day, nurses face the challenge of caring for complex, acutely ill patients and their families while reflecting that care and their observations in their documentation. Numerous documentation methods have been developed and implemented in a variety of settings, attempting to accurately depict these observations, as well as meet regulatory and organizational requirements. As health information systems were steadily integrated into most healthcare facilities over the years, this gave rise to the electronic health record. As the value of this data was realized, technology has since leveraged the data collected from electronic documentation to improve patient outcomes. This course will discuss how nursing documentation has evolved in the digital age, the benefits to be realized, the ongoing challenges, and the landscape for the future.

THE EVOLUTION OF NURSING DOCUMENTATION

The importance of recording the clinical observations and discrete patient data via nursing documentation dates back to the late 1800s and is primarily attributed to Florence Nightingale.

Nightingale was the first to record her observations but, in the United States, it was nurse supervisor Linda Richards that transitioned what was then a verbal report to the physician of a patient's status to a written report, creating "a system for charting and maintaining individual medical records for each patient" (Michaels, 2018).

The recording of patient data not only results in a written recording of the patient's condition, but it also provides the ability to trend progress and ensure communication of the same. Historically a manual process, documentation was only available to those that had their hands on the physical patient chart and was dependent on good handwriting for accurate interpretation.

Fast forward to 100 years later and health information systems began to address the benefits of electronic documentation, providing both greater readability as well as accessibility.

While a variety of nursing terminologies exist, (Table 1), there are two major styles of documentation: a narrative/textual note (a discrete data entry via an instrument) or a measured observation, (standard data field). Some may argue that the narrative note tells a better "patient story", but the discrete data entry has more trending and analytical advantages (Bush et al., 2017). Potter and colleagues cite six principles of nursing documentation: factuality, accuracy, completeness, timeliness, organization, and compliance with standards (2016)

PURPOSE OF DOCUMENTATION

The American Nurses Association (ANA) states that "clear, accurate and accessible documentation is an essential element of safe, quality, evidence-based nursing practice".

"Charting should be factual", recording "what is actually seen, heard or done" (Michaels, 2020). It reflects a patient's current condition and response to treatment.

Nursing documentation has rich content that has evolved from the primary intent of depicting a patient's status and communicating that status to other healthcare providers, to many other purposes including compliance with regulations (CMS, Joint Commission), evidence in legal situations, reimbursement, research, analytics, and quality improvement. With nursing having the most direct contact with patients, they, in turn, contribute the most data to the electronic health record (EHR; Delaney et al., 2017). This demonstrates not only the contributions to patient care outcomes and the recording of this information, but also serves the important purpose of communication and interaction between nurses and other health professionals (Prasetyo, 2019).

This multi-purpose nature has resulted in what many have referred to as the burden of documentation. When another study or regulation is put into place, it is often nurses that are asked to enter the data, hence not only increasing the time it takes to document initial assessments, shift assessments, and discharge summaries, but taking time away from direct patient care.

STANDARD TERMINOLOGY

As many contribute to the EHR, the ability to trend the discrete data and use the data for clinical decision support or analytics requires some standardization of the data.

The American Nurses Association's (ANA) supports the use of recognized terminologies as valuable representations of nursing practice and to promote the integration of those terminologies into information technology solutions. Standardized terminologies have become a significant vehicle for facilitating interoperability between different concepts, nomenclatures, and information systems (ANA, 2018).

Table 1: Standard Nursing Terminologies

Interface Terminologies	Minimum Data Sets
Clinical Care Classification System (CCC)	Nursing Minimum Data Set (NMDS)
International Classification for Nursing Practice (ICNP)	Nursing Management Minimum Data Set (NMMDS)
North American Nursing Diagnosis Association International (NANDA-I)	Reference Terminologies
Nursing Interventions Classification System (NIC)	Logical Observation Identifiers Names and Codes (LOINIC)
Nursing Outcomes Classification (NOC)	SNOMED Clinical Terms (SNOMED CT)
Omaha System	
Perioperative Nursing Data Set (PNDS)	
ABC Codes	

Table adapted from ONC HIT, Standard Nursing Terminologies: A Landscape Analysis May 15, 2017.

TYPES OF DOCUMENTATION

There are a variety of nursing documentation methods, all of which approximate the nursing process. The two primary documentation styles for data entry in the EHR are: structured and unstructured. Structured data provides the user with a predefined list to choose from, while unstructured data is free form in a comment or note.

Structured data entry – (Query based)

Structured data provides a question or query to respond to with a list of choices. This standardizes the data (see Table 1) that can be used for several purposes, both real-time in caring for the patient at hand as well as retrospective studies to improve outcomes. By standardizing the responses to a specific query, data can be easily trended and a graphic representation of the data can also be displayed. This provides a longitudinal view of the data where improvement or deterioration is easily recognized. These standard data fields not only provide the ability to trend data across time, but they also provide the ability to use the data for clinical decision support. Clinical decision support (CDS) applies algorithms to the data and "requires computable biomedical information, person-specific data, and a reasoning or inferencing mechanism that combines knowledge and data to generate and present helpful information to clinicians, patients, and care team members as care is being delivered. This information must be filtered, organized, and presented in a way that supports the current workflow, allowing the user to make an informed decision quickly and to take action on that decision" (Tcheng et al., 2017).

Clinical Decision Support Systems (CDSS) can be accomplished with Expert System (ES) or Machine Learning (ML). Expert systems rely on "sophisticated rule-management system" (Sloane, 2020), using "if, then" logic. Ideally, both ML and ES prompt the user at the point of care and are based on "statistical inferences", matching relevant algorithms to similar "patients, treatments and outcomes" (Sloane & Silva, 2020). For example, a study by Trinity Health on structured data entry allowed an algorithm to be used against the data, thereby prompting prophylactic recommendations and preventing venous thromboembolism (VTE) (Delaney et al., 2017).

Flowsheet-based documentation can include time-based and semi-structured data (Delaney et al., 2017). This provides the ability to see this data across time and may be entered manually into the online flowsheet or brought in via an interface from patient care monitors, vents, IV pumps, etc. The ability to bring in data from instruments such as those mentioned here decreases documentation time, relieves the burden of documentation, removes the risk of transcription errors, and improves the accuracy of the data. In a study by Collins and colleagues (2018), documentation burden was quantified within EHR flowsheets with "mean rates of 633-689 manual flowsheet data entries per 12-hour shift in the ICU and 631-875 manual flowsheet data entries per 12-hour shift in acute care, excluding device data" (Collins et al., 2018). This equated to "a nurse documenting 1 data point every 0.82-1.14 minutes,

despite only a minimum data-set of required documentation. Increased automated device integration and novel approaches to decrease data capture burden (e.g., voice recognition) may increase nurses' available time for interpretation, annotation, and synthesis of patient data while also further advancing the richness of information within patient records (Collins et al., 2018).

Evidence-based practice! Beginner users of the structured clinical templates required at most 70.18% more time for data entry.However, as users became accustomed to the templates, they were able to enter data more quickly than free-text entry: at least 1 minute and 23 seconds (16.8%) up to 5 minutes and 42 seconds (27.6%; Hwang,et al., 2020)

Narrative notes

Narrative-style nursing documentation, also called narrative notes, nursing notes, or progress notes, is one of the oldest methods of nursing documentation. It is a diary or story format in simple paragraph form used to describe the patient's status and the interventions, treatments, and patient responses that have occurred during the shift. It is frequently used in acute, long-term, ambulatory, and home care settings.

The narrative note is the oldest and perhaps most familiar style of documentation. Though they easily tell the patient story, the narrative note is time consuming to document and to review. Primarily a subjective accounting, any discrete data within the note can be difficult to find and even harder to compare previous observations. Structured notes, using one of the styles identified in Table 3, do provide for a consistent format, but the comparative findings require additional effort to reveal trends. The adjunct of flowsheet documentation is a good supplement to the narrative note, though redundant documentation typically results from the use of both methods.

Before the development of flow sheets, narrative notes were the only method used for documenting nursing care. However, narrative notes may become lengthy and time consuming with routine care and normal assessment findings reported along with significant findings and identified problems. Narrative notes pose difficulties in reviewing patient charts and in accessing patient data. It is often difficult to quickly identify the most important information because there is no single correct order in which to document patient events. Although narrative notes are still one of the most used documentation methods, they are seldom the primary method and are more typically used as adjunct to structured data entry. Table 2 provides an example of a narrative note.

Table 2: Narrative Note

6/16/21. 1045: Patient found sitting on floor next to bed. States he does not know how he got there. VS = BP 142/89; P 76; R 20.

Oriented to time and place. Appears in no distress. Peter Downs, CNA, called to assist getting patient into chair. Patient able to move all extremities and stood up through own efforts. CNA assisted patient to bathroom.

Voided approximately 250 mL clear, pale yellow urine. Patient returned to chair with no assistance. No bruising, redness, or abrasions noted to hips or legs. Dr. Jones notified of patient's condition and assessment. No new orders received. Call light within reach. Patient instructed to call for assistance with ambulation.

Lori Johnson, RN

Note. From Western Schools, © 2019.

Structured narrative notes

There are a variety of nursing documentation methods, all of which approximate the nursing process.

While taking advantage of a narrative style, the note reflects structured narrative to reflect patient problems or diagnoses, observations, actions to be taken, and evaluation of those actions. Each note includes a signature and date and time. Some of these styles are identified in Table 3.

Table 3: Narrative Note Styles

SBAR	Situation, Background, Assessment, Recommendation.
PIE APIE	Problem Intervention Evaluation. Assessment Problem Intervention Evaluation.
SOAP SOAPIER	Subjective, Objective, Assessment, Plan. Subjective, Objective, Assessment, Plan, Intervention, Evaluation, Revision.
DARP	Data, Action, Response, Plan.

Charting by exception is another style of nursing documentation. With fear regarding the old adage "if you didn't document, you didn't do it", organizations that use this style of nursing documentation have specific guidelines on charting a finding when it is not normal (Lapum et al., 2020) and providing a list of normal ranges and activities. A note is only entered when findings are outside of these norms. For instance, if an incision showed no signs of infection, there would be no documentation of the site (Lapum et al., 2020).

Nursing Admission Assessment is a standard documentation practice to assess and "document a patient's current condition, previous medical history, allergies, prescription drugs and primary complaint at the time of their admission to the hospital" (Lapum et al., 2020). The process combines an interview style assessment as well as physical observations. The completed assessment forms the basis for the plan of care with electronic systems prompting the nurse with conditions or problems to be addressed as part of the care plan.

The Nursing Care Plan identifies problems to be addressed by nursing care and within nursing's scope of practice. Interventions that address the problem and outcomes to be achieved are documented in the plan of care. The interventions coupled with physician orders to be carried out by nursing may become part of the flowsheet documentation or narrative note, depending on the type of observations that are made. The care plan is modified as the patient progresses or declines and includes patient education and discharge planning.

Structured data entry

Discrete data that is documented either by entering data into the EHR or via an interface to monitors can automatically graph this data. Similar to the flowsheet that, at a glance, allows the nurse to see trends, the graph has visual cues identifying if the data is out of range. Common graphics include vital signs, daily weight, and intake and output (Lapum et al., 2020). This may also include medications in comparison to vital signs and lab results in order to visualize the impact of the treatment plan more easily. Surveillance tools available in an EHR can apply algorithms to the data and warn the clinician proactively of signs of deterioration in the patient's condition.

The medication administration record (MAR) has the most obvious value in point of care documentation. When combined with a bar-code verification, the EHR can provide safety assurances of the five rights as well as display related results to ensure safe administration.

A clinical pathway is a multi-disciplinary care plan with a series of steps based on evidence (Rotter et al., 2019):

1. It is used to translate guidelines or evidence into local structures.
2. It details the steps in a course of treatment or care in a plan, pathway, algorithm, guideline, protocol, or other "inventory of actions".
3. It aims to standardize care for a specific clinical problem, procedure, or episode of healthcare in a specific population.

Evidence-based practice! The Cochrane Collaboration, consisting of 27 studies and 11,398 participants, proved reductions in length of stay and hospital costs for those on critical paths compared with those not on pathways. Meta-analysis revealed reduced in-hospital complications and two studies reported improved professional documentation(Rotter et al., 2019).

Case study 1

A 40-year-old female arrived to the ER via ambulance after a car accident. On a backboard and with cervical collar in place, the patient is moved to a bay in the ED. The patient is awake, able to answer questions, and complaining of pain in her right leg and a headache. The patient states that upon making a left turn, the other driver ran through a red light impacting her vehicle on the driver side. Vital signs are recorded with a temperature of 99, pulse of 92, respirations of 20, and blood pressure 124/88, lungs were clear bilaterally to auscultation. A neuro check is performed with a Glasgow Coma Scale of 15/15 and PERRLA within normal limits. There is bruising to the patient's forehead and leg, but no bleeding or open wound. Past history reveals no medical or surgical history. After an x-ray of the spine revealed no fracture, the backboard was removed.

Upon further questioning of the patient's headache, she reveals a worsening headache, ringing in both ears, and nausea. After several hours of observation, the patient reported no worsening of symptoms. She was discharged to her family with instruction to avoid exposure to bright lights, minimize TV and computer screen usage, rest, and to contact her primary care provider if symptoms worsened.

Self-Assessment Quiz Question #1

Which of the following data is best represented with a graphical appearance to easily recognize trending data?

a. Vital signs.
b. Description of headache.
c. Removal of cervical collar.
d. PERLLA.

Self-Assessment Quiz Question #2

If charting by exception (CBE), which observation does not need to be documented?

a. Description of headache.
b. Patient's report of ringing in ears and nausea.
c. PERLLA.
d. Discharged to patient's family.

Self-Assessment Quiz Question #3

Which of the following are present in a patient's plan of care?

a. Pain management.
b. Discharge instructions.
c. Activity tolerance.
d. All of the above.

To achieve the retrievability and CDS of a narrative note, natural language processing (NLP) pulls key words out and "standardizes" them. Once the text is converted to structured data, the data can then be used to enable algorithms to be run against the data, using it to achieve better outcomes. This can benefit future patients. In order to benefit patients currently being treated, the challenge is the real-time need of "deciphering that data" and providing the user with the CDS at the point of care (Chapman, 2019). This provides opportunities for other types of narrative notes such as voice dictation or voice to text, where the spoken word is converted to the written text.

OVERVIEW OF THE EHR

It is well known that healthcare is slow to adopt technology, lagging behind most other industries (Adler, 2016). Kandel et al. (n.d.) attribute this to safety and workflow. "Healthcare is conservative, but it is conservative for a reason: lives literally depend on it. Every new piece of technology needs to be bulletproof" (Kandel et al., n.d.). And with clinicians having an ever-increasing workload and higher patient acuity, a disruption in workflow can cause a great burden to the clinician and perhaps the patient.

The Electronic Health Record (EHR) is "a digital version of a patient's paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users"(healthit.gov, 2019). Information reflecting the patient's condition and progress inclusive of all tests, procedures, and clinical observations can be provided by and are available to be shared with other care providers across a single facility or throughout the healthcare organization.

EVOLUTION OF ELECTRONIC DOCUMENTATION

The tracking of admissions, discharges and transfers (ADT) were in use by medical institutions long before clinical data became part of the EHR. Demographic data were collected and usually tied to finances and billing. When computers first began appearing on nursing units, they were often used to order supplies, laboratory tests, and other diagnostic tests and procedures. Laboratory information systems were an early entry into the market in the late 1960s by MEDITECH and Cerner. Test results were then available online. The unit secretary usually handled the entries for orders and procedures, transcribed from the paper record, thus eliminating the paper Kardex and paper requisitions. Initially, the unit secretary was the most computer-literate person on the unit.

The beginnings of an electronic system for patient records were seen as far back as the 1970s, but it was in the mid-1980s when software was developed for use in nursing documentation. The earliest uses involved individualizing care plans for placement in a patient's medical record. In many cases, individual departments purchased computers and software specific to the department, referred to as a best of breed solution, specific to the needs of that one department. Challenges related to the incompatibility of systems resulted from the rapid development of an increasing number of software companies developing programs for a variety of services (Lee et al., 2020).

In the early stages of computerization of hospitals, laboratory and other test results were printed from their individual systems and sent to the nursing units to fill the paper chart, typically held in a binder. As systems progressed, these results became available online by viewing the computer system. As capabilities progressed, systems were then able to computerize patient supply charges, which led to more accurate hospital billing and supply management.

One of the next steps in computerizing the medical record during the 1990s was adding order entries by the clinicians

themselves. Many physicians and nurses resisted order entry because they were uncomfortable with computer technology, could not type, or believed that direct entry was too time consuming. Computerized physician (or provider) order entry (CPOE), wherein physicians input orders directly into the computer, is the most desirable method of data entry. This process reduces transcription errors related to illegible physician handwriting (Agency for Healthcare Research and Quality, 2017). Historically depending on others to do this on their behalf, physicians saw this as an extra burden that they did not have time for. CPOE, however, can provide physicians with clinical decision support at time of entry instead of needing follow up for adjustments to the order after the fact. Additional details required to perform the test can be prompted right within the order and provide conflict checking for appropriateness for the patient.

Adding pharmacy systems to electronic capabilities further reduces the chance for error, removing not only the potential for a transcription error, but adding the ability to check for drug interactions and contraindications. Pharmacy systems initially provided a printed medication administration record, which reduced the risk associated with transcription of orders and provided a clear, legible record. As nursing information systems progressed and became integrated with pharmacy systems, the online MAR combined with bedside medication verification (BMV) provided an opportunity of assisting nurses with the five rights of medication administration.

As EHRs continue to improve the user experience and familiarity with the use of computers has become ubiquitous, devices at the bedside or on carts are commonplace. Although computers are easier to use and are quite common at the bedside, documentation has gone beyond just desktop computers. Currently available electronic documentation systems may also use wall-mounted (touch screen), handheld, or other portable devices to record patient data, including assessment information, routine care, medication administrations, treatments, and changes in condition. Bedside systems using standard keyboards, voice-activated systems, and other devices allow nurses to promptly document vital signs, routine care, and changes in status. These devices provide the ability to continually update patient information in addition to providing accessibility by multiple healthcare providers. Networking an entire hospital with compatible programs enhances the use of computers (D'Souza et al., 2019).

Some information systems recommend nursing diagnoses based on predefined assessment data previously entered into the system. Systems that are interactive prompt the nurse with questions and recommendations related to the entered information. These questions and diagnostic recommendations foster quick and thorough documentation. All the information is available in the computer program for individualization of the plan of care. Additional tools include the use of clinical guidelines incorporated into the EHR and clinical decision support that assists in guiding practice for physicians and nurses (Sloane & Silva, 2020).

Current developments include building a comprehensive system that uses various data collection components and broadening the scope of computer capabilities for multidisciplinary uses. Computerized documentation is flexible and expandable, making it capable of meeting the evolving needs of each clinical specialty and subspecialty. The development of the EHR must grow to account for expanding knowledge bases and sophistication of users, including the input of the professionals who are the end users. EHRs, even those that are evolved, are simply tools used; they do not replace the critical thinking and practice of healthcare professionals (Sloane & Silva, 2020).

SELECTING A DOCUMENTATION SYSTEM

Selecting a documentation method that ensures optimal communication, simplifies

the documentation process, and meets required regulations is difficult. It is important to con- sider the staffing mix of the hospital, specialty unit, or agency providing care. If unlicensed assistive personnel are part of the staff, their role in documentation must be evaluated. On an all-RN unit, staff are comfortable with a variety of documentation methods, whereas a unit staffed with a mix of educational backgrounds may need more guidance by using drop down lists and data field prompting.

Though the use of computers has become ubiquitous, the knowledge and skills of the staff must also be considered. Nurses have varying degrees of exposure to different types of documentation and age, educational background, and work experiences influence their documentation skills. Nurses may resist a new documentation method if they do not possess the knowledge and skills to understand the process.

Changing documentation systems can be costly; therefore, determining the financial outlay of a new documentation system is essential. Cost estimates should include planning and preparation time, printed materials, design and development of new forms, and educational time. With nursing staff being the largest volume of staff in an organization, this is a substantial effort.

Another critical consideration in the process of changing documentation methods is education. A sound educational program must be developed and repeated as often as necessary. Multiple methods of education including classroom training, e-learning and one: one support may be required. After implementation, the process will need monitoring for compliance and troubleshooting for any problems that may develop. This is also an opportunity to optimize the system to better reflect workflow (Karp et al., 2019).

Regardless of the documentation method that is selected and whether documentation is via a paper or electronic health record, vital components must be included. The method must provide for clear communication and use standardized language. The components of the nursing process must be reflected, from assessment through evaluation. Patient progress and outcomes must be plainly described (Moghaddasi et al., 2017).

SUPPORT FOR ELECTRONIC NURSING DOCUMENTATION

The value of electronic documentation is recognized by nurses but has traditionally been hampered by software that lacks usability as well as a shortfall of available devices. If a computer is not available for documentation, it will result in retrospective documentation. While individual devices are often made available to physicians, nursing ends up sharing these devices on a shift. Although EHR vendors will often recommend that there be enough computers for the greatest number of staff on a shift (typically the day shift) that are then shared from shift to shift, this is rarely met. Mobile devices, often referred to as point of care (POC) devices can be less expensive and hence easier to supply the right numbers (McNicol et al., 2018). The most successful example of POC devices that quickly prove their efficacy are those used for bedside medication verification. The process of scanning the patient and then the drug compares against the medication administration record (MAR) and ensures the five rights of administration: right patient, right time, right dose, right drug, right form. A warning will display if any of these are not correct. Had a POC device not been in use, the wrong medication might have been administered and the error not found until after the fact. The first time the scanner prevents a nurse from making that error, they forever recognize the importance of POC, aiding in error reduction and adverse drug events (McNicol et al., 2018).

Case study 2

Mr. Bridgeman is a 78-year-old male with a history of CHF and diabetes. He is physically active and has no history of dementia. His wife heard a crash in the next room and found her husband on the floor after having fallen. Mr. Bridgeman is in extreme pain and unable to assist himself in getting up, so Mrs. Bridgeman calls an ambulance and he is taken to the ER. Mr. Bridgeman is triaged and initial assessment information is gathered, including the history of CHF and diabetes managed with diet and exercise. He is assessed for a suspected hip fracture and still complaining of severe pain on a scale of 9 out of 10. Mr. Bridgeman is given Percocet while waiting for his x-ray. Lab work is ordered in preparation for surgery, anticipating a fractured hip. Upon confirmation of the fracture, Mr. Bridgeman is prepped for surgery and taken into the OR 5 hours later. The surgery goes well, and post-op is taken to the recovery room and later transferred to the orthopedic unit. Handoff communication provides a narrative summary in the progress notes of Mr. Bridgeman's recovery room stay. New orders are provided but there are questions regarding which recovery room orders are to be discontinued. The physician is called for further instructions. In the meantime, the patient is complaining of pain (9 out of 10) and the electronic medication administration record (eMAR) is reviewed for pain medications. Both the recovery room medications and the new orders for pain meds are listed on the eMAR, but no recorded medications appear as given in the recovery room. The nurse checks the hand-off report and determines that IV morphine was given twice during recovery. Seeing both the NPO order and a diet as tolerated order, the nurse administers the oxycodone order to the patient for pain, but in a rush to try to relieve the patient of pain, administers the medication without the use of the barcode scanner. Having just given the medication to the patient, the nurse then scans her badge, the patient arm band, and the barcode on the unit dose and receives a dose warning regarding the medication. The warning indicates that the nurse has scanned less than the prescribed amount and she retrieves a second unit dose to achieve the ordered dosage. Now having confirmed the five rights of medication administration with the bedside medication verification process of scanning, the nurse, patient, and medication before medication administration, the nurse is prompted to also record the degree of pain (1-10 scale) as part of the eMAR documentation. Thirty minutes later, the nurse is alerted via the EHR and eMAR that a pain reassessment is due.

Self-Assessment Quiz Question #4

The recovery room had no recorded medication administration on the eMAR. The potential reasons for this include all of the following EXCEPT:

a. The recovery room uses a best of breed system and hence is on a different system than the inpatient units.
b. The recovery room still documents on a paper flow sheet and only enters narrative notes into the system.
c. The recovery room does not document medication administrations.
d. All of the above.

Self-Assessment Quiz Question #5

Medication administration using barcode verification with the eMAR provided all of the following clinical decision support warnings EXCEPT:

a. Wrong patient.
b. Wrong dose.
c. Documentation needed.
d. Reassessment needed.

Self-Assessment Quiz Question #6

In addition to the clinical decision support provided, what other advantages to electronic medication documentation exist?

a. By reviewing the eMAR, other nurses can quickly see when a next med is due.
b. By reviewing the eMAR, nurses can quickly and easily see when the last med was given.
c. Entry of clinical data can compare the pain level of the patient to the medication administration times.
d. All of the above.

Medication administration is not the only benefit for POC. The portability of the device makes it easy to use them for rounding and handoffs and they can also be used to engage the patient in their care by showing them their progress on the device. Previous studies have shown that patient's do not feel engaged in care with POC, but that when time is taken to include the patient in the documentation or the review of same, an opportunity for better patient engagement exits (McNicol et al., 2018). If this same device form factor is used by the EHR vendor for their patient portal, nurses can use this as an opportunity to review features and functions of the portal with the patient before discharge. Patients comfortable with POC-HIT concur that it can "support their involvement and promote recovery" (McNicol et al., 2018).

Much of documentation still occurs at the nurse station and hallway, with documenting in patient rooms falling below the other two at 1/3 of the time spent, resulting in a lack of real-time documentation (Yen et al., 2018). This creates several drawbacks. If information was recorded on paper and then transcribed into the EHR, this results in redundancy as well as the possibility of transcription errors. If information is not recorded at the time of observation, this can also result in omission or incorrectly recorded data. In a study by Yanamadala et al. (2016), it was found that electronic documentation did not prove better quality outcomes if the documentation was used as a "recording mechanism after patient care" as opposed to point of care documentation (Yanamadala et al., 2016). A study by Ahn and colleagues (2016) found that some documentation is not even recorded during a nurse's shift. Nurses with more than 1 year of experience were more likely to document in a timely manner, as were those on evenings and nights compared to day shift nurses, with the assumption that a higher number of admissions and post-op patients impact timeliness (Ahn et al., 2016). A thorough search of studies done on electronic documentation by McCarthy and colleagues (2018) did not conclusively determine that electronic documentation improves quality of care or patient safety, but did find some evidence indicating that in acute hospital settings it is time saving and reduces rates of documentation errors, falls, and infections. Further evidence found (Hsieh et al., 2016) that providing nurses with tools such as "SmartPhrase" and visual cues for required data fields and/or errors has the potential to enhance the quality of documentation, facilitate data collection, and reduce rates of falls and infections. The prompting of relevant information at the time of documenting can reduce unnecessary documentation, and well-built templates can reduce documentation time (Hsieh et al., 2016). What must be stressed is the opportunity for clinical decision support available at the point of care with real-time documentation. Retrospective documentation eliminates this opportunity and potentially puts the patient at risk (Tcheng et al., 2017).

A study done by Liao and colleagues (2018) found a decrease in "recording time per shift" for both junior and senior (greater than 10 years' experience) nurses by 29 minutes and 15 minutes respectively.

Documenting at the point of care not only provides the opportunity for actionable clinical decision support, but it also provides the opportunity for other caregivers to have immediate access to this information. "Physicians and members of other interdisciplinary teams, such as therapists and dietitians, also benefit from the system as they can check the patient's relevant assessments or treatments online at any time and provide the patient with the timeliest and most accurate rehabilitation or nutrition prescriptions" (Liao, et al., 2018). In the absence of real-time documentation, discrete documentation used for clinical decision support cannot be triggered in a timely manner and hence prevents nurses and other clinicians from being able to act on the information.

The hesitancy to document at the bedside can be attributed to feeling it is disruptive to patient care (Ahn et al., 2016), poor system usability, interruptions by other care providers or family, and discomfort documenting in front of the patient, as well as patients themselves feeling that this can detract from effective communication (McNichol et al., 2018). The study by Ahn and colleagues (2016) did not reveal any differences in the timeliness of documentation when compared across different EHR systems.

Clinical Consideration: Some evidence from our review indicates that implementing electronic nursing documentation in acute hospital settings is time saving and reduces rates of documentation errors, falls, and infections (McCarthy, et al. 2019).

Though real-time documentation at the point of care is desired, there are instances where retrospective documentation still occurs. In those situations, the actual time of the observation should be identified as well as the time that the information was entered into the record.

REDUCING THE BURDEN OF DOCUMENTATION

"Over the last few decades, nurses have increasingly been burdened with documentation to meet regulatory and quality reporting requirements" (Karp et al., 2017). Required documentation is often expanded, yet rarely is any taken away. As Effken and Weaver (2016) stated: "the house of nursing documentation needs cleaning". A research study by this team (Karp et al., 2017) identified 40 data elements as essential to a quality patient admission assessment, hypothesizing that limiting documentation to these would:

- Increase the proportion of essential items completed.
- Decrease the documentation time required to complete the admission assessment.
- Reduce the number of mouse clicks.

While it may seem obvious that reducing the number of data elements would provide these results (the research site decreased their minimum data element from 215 to 58 data elements--a 73% reduction; Karp et al., 2017), the importance of reviewing documentation templates to ensure data fields are essential was not emphasized enough. If an organization sees that the easiest way to comply with a new regulation or reporting requirement is to add data elements to the nurses' workload, rarely do they take the time to simultaneously review what is no longer needed. This results in a "more is more" mentality instead of looking at the scope of the documentation. This study also compared the quality of the documentation before and after reducing the required data elements. While efficiency and reduced mouse clicks are obvious, it is the quality that is of most interest here. Interestingly, the study proved that, given the same data fields in the pre vs post surveys, a higher percentage of completion of these essential data fields occurred, increasing from 48% to 54% (Karp, 2017). In this case, less was more.

One method of decreasing the burden of documentation is to decrease non-meaningful documentation and increase meaningful documentation. To successfully do that, three things must be examined (Englebright, 2021:

1. Is each data element necessary for patient care?
2. How is each data element used? Reports, Alerts, Reminders?
3. How often do the reports, alerts, and reminders create actions?

Documentation then needs to be timely, concise, actionable, and delivered to the appropriate decision-maker when needed (sharable; Englebright, 2021). Both actionable and deliverable depend on point of care documentation to make an impact.

Over the years, there have been many time and motion studies to determine how to provide for more efficient foot traffic to and from patient rooms for nursing staff, e.g., where supplies should be located, configuration of the nursing unit, etc. More recently, time and motion studies have been performed to determine the amount of time spent on nursing documentation vs direct patient care. Baker and colleagues (2019) conducted a time and motion study recording various tasks, the location performed, and duration of each. "The workflow of nurses and patient care technicians, constantly in and out of patient rooms, suggests an opportunity for delivering a tablet to the patient bedside" (Baker et al., 2019). This would provide joint review of information via the tablet between patient and nurse. The average time between visits to a given room is consistent with bringing the tablet to a patient in one visit and retrieving it at the next. However, the relatively short duration of direct patient care sessions could potentially limit the ability of nurses and patient care technicians to spend much time with each patient on instruction in the technology platform or the content (Baker et al., 2019).

Another time and motion study monitored documentation time post implementation of an EHR. In this case, the transition from paper-based to an EHR did not significantly change the amount of time at the bedside, but there was an increased time spent in documentation (Walker, 2019). What was not evaluated in the study was the location of the devices, nor was the comparison of documentation requirements on paper vs electronic. Implementing a new documentation system can often result in additional data recorded to satisfy other use cases. For instance, The Patient Protection and Affordable Care Act (ACA) reimbursement models, Meaningful Use (MU) mandates of specific EHR requirements, along with other regulatory requirements have altered documentation in a manner not conducive to efficient documentation or workflow (Moy et al., 2021). Commonly referred to as the burden of documentation, this has led to increased medical errors increased time spent documenting, and burnout, without resulting quality improvement (Moy et al., 2021). An effort to reduce the documentation burden has been the focus of the 25×5 Symposium, which was "developed to establish strategies and approaches to reduce clinician documentation burden on US clinicians to 25% by 2025" (Collins et al., 2021).

Their goals included:

1. Engage a diverse group of key stakeholders and leaders focused on reducing documentation burden.
2. Assess the likely potential for burden reduction within categories of documentation burden, including identifying 'low hanging fruit' for 'quick wins' without adversely impacting quality or access to care.
3. Establish approaches for immediate (less than 3 months) and short-term (6 months) reduction in clinical documentation burden.
4. Generate approaches to longer term (10 years) elimination of clinical documentation burden .

(Collins et al., 2021)

Suggested solutions include taking advantage of other data – other clinicians' entries, monitor data, and referring to data instead of redundantly entering data. Successful efforts by Hospital Corporation of American (HCA) followed "an evidence-based design that aligns minimum documentation requirements

with ideal workflow" (Michel, 2018). This included having specialists such as dietitians and therapists record their own documentation without nursing redundantly entering the same information. Screening questions resulted in the identification of these clinicians' role in the patient's health; this relies on trusting each other's documentation. Results of this have included saving up to 2 hours of documentation time per nurse per shift (Michel, 2018).

Evidence-based practice! An evidence-based design that aligned minimum documentation requirements with ideal workflow resulted in saving up to 2 hours on documentation per nurse, per shift (Michel, 2018)

VALUE-ADDED DOCUMENTATION

The benefit of being able to utilize the data for clinical decision support was mentioned previously, but additionally, charges for procedures, time spent, or materials used can also be a by-product of documentation. Any additional use of the information that can take action behind the scenes creates a value-add opportunity. Other have long benefited from nursing documentation, anything else that can be done on behalf of that documentation can not only help diminish the burden of documentation, but it can also replace other documentation. For example, many acuity systems rely on a separate form that is filled out depicting a patient's level of care. If, instead, documentation can record a degree of severity as a byproduct of the documentation, this would eliminate bias and redundant documentation. Supplies and timed charges can also be a byproduct of documentation. When fully integrated with inventory and billing, these are components that benefit others while not adding burden to documentation. Moy and colleagues (2021) scoping review also identified streamlined documentation as a byproduct of the EHR.

Case study 3

Mrs. Smith is a 50-year-old female with a history of hypertension and high blood pressure. She has no family history of heart or lung disease and is a current smoker. Mrs. Smith experienced sudden chest pain described as an "elephant sitting on my chest" with pain radiating to her arm and back. She is diaphoretic and feeling weak. Upon calling an ambulance, Mrs. Smith was transported to the Emergency Room.

Initial assessment revealed vital signs of 128/80, with a normal heart rate and rhythm, no murmur detected. Blood pressure rose to 158/82, then returned closer to initial recording of 130/82. Vital signs were recorded and automatically alerted the physician in the EHR. Upon receipt, the physician ordered an EKG. The charge for the EKG was automatically sent to billing and supplies used automatically depleted inventory upon completion of the EKG. The initial EKG showed slight changes compared to an earlier EKG available in the EHR for comparison. Cardiac enzymes were normal as was a chest x-ray, both requiring entry of suspected diagnosis at time of ordering with repeat of cardiac enzymes reflexed (automatically ordered). Charges were automatically sent to billing upon completion of the test.

Nursing documented the vital signs and triage assessment with the emergency severity level auto-calculated at a level of 2. Nitroglycerin drip, aspirin, and beta blockers were ordered and administered via eMAR BMV, alerting the nurse of the need to enter pulse and blood pressure before administration as well as a display of the last set of vital signs. The system prompted the nurse with vitals being within acceptable range to administer the nitroglycerin.

The patient was admitted to the cardiac care unit and scheduled for a cardiac catheterization the following morning. The patient was placed on a cardiac monitor and data automatically populated the EHR, trending the data along with the recordings taken in the emergency department. The admitting nurse was able to review all information documented in the emergency room and reference that information, confirming it with the patient instead of re-entering the information.

Mrs. Smith was glad that the nurse was familiar with her information and she did not have to repeat the same answers that she had provided in the ER.

An echocardiogram was ordered and revealed left ventricular hypertrophy with normal systolic function and aorta. The patient's pain persisted, and vital signs continued to populate the EHR via monitor interface every 10 minutes per protocol. When the patient's blood pressure suddenly dropped to 70/60 with a heart rate of 136, the monitor alarmed, and results were immediately and automatically alerted to the nurse's electronic flowsheet and the physician via EHR and text message. Quick action by the team avoided a code.

Self-Assessment Quiz Question #7

Which of the following does not reflect clinical decision support prompts?

a. Required data entry at time of order.
b. Required data entry at time of medication administration.
c. Monitor data sent to the EHR.
d. All of the above.

Self-Assessment Quiz Question #8

Which of the following is not an example of value-added documentation?

a. Automatically charging for tests upon completion.
b. Reflex ordering of cardiac enzymes.
c. Automatically charging for supplies and decrementing inventory.
d. Calculation of severity level based on documentation of patient status.

Self-Assessment Quiz Question #9

Which of the following reduce the burden of documentation?

a. Auto-calculation of severity level.
b. Referring to previous documentation instead of re-entering data.
c. Monitor interface sending data to the her.
d. All of the above.

Self-Assessment Quiz Question #10

Which method of documentation is best suited for inclusion of patient's description of her chest pain?

a. Pain scale of 1-10.
b. Narrative note with exact words of patient's description.
c. Flowsheet documentation.
d. None of the above.

INCENTIVE REIMBURSEMENT

The Patient Protection and Affordable Care Act (ACA) reimbursement models, Meaningful Use (MU) mandates, and a regulatory-rich environment have drastically altered clinical documentation workflow and communication in routine healthcare via the EHR. The Patient Protection and Affordable Care Act, also known as the Affordable Care Act, and the American Recovery and Reinvestment Act of 2009 identified many necessary changes for healthcare, including the use of the EHR. As part of these programs, incentive payments from the Centers for Medicare & Medicaid Services (CMS) were available to eligible providers and hospitals to increase the interoperability and flexibility of certified health information technology products. Promoting Interoperability (PI); formerly known as Meaningful Use Stage 3 is a mandate for providers and hospitals to improve safety, quality, coordination of care, and communication in healthcare. PI in EHR is using certified technology to improve quality, safety, and effectiveness; reduce health inequalities; involve patients and their families; enhance care coordination; and preserve the privacy and security of protected health information. It consists of the use of an EHR in a significant or meaningful manner, use of the technology of the EHR for the electronic exchange of information, and use of EHR technology for submission of clinical quality measures (formerly called core measures; Centers for Disease Control and Prevention, 2017).

PI has three stages: Stage 1 of the PI program was announced in 2010 and concentrates on data sharing and tracing clinical conditions for better coordinated care. Stage 2 of PI began in 2014 and broadens the use of EHR software for health information exchange. Stage 3 began in 2016 through the federal Health IT Policy Committee (now Health Information Technology Advisory Committee) and focuses on a more collated information network, from labs to immunization information (Centers for Disease Control and Prevention, 2017; CMS, 2021).

The requirements for PI, including deadlines for completion of its stages, are dynamic. Goals for PI include a focus on safety and high-quality patient outcomes, use of decision support for conditions identified as high priority, patient access to tools for self-management, access to comprehensive patient data, and improvement in population health. For PI, eligible hospitals must comply with four out of six measures (Centers for Disease Control and Prevention, 2017; CMS, 2021).

Components of PI through the EHR include (CMS, 2021):

- Patient demographics.
- Vital signs.
- Advance directives.
- Medication reconciliation.
- Drug interactions.
- Allergies.
- Smoking status.
- Computerized physician order entry.
- Clinical decision support.
- Interdisciplinary communications.
- Confidentiality.
- Transitions of care.
- Public health.
- Clinical data reporting.
- Patient education.
- E-prescribing.
- Send Summary of Care from one EHR to another.
- Request/accept summary of care from one EHR to another.
- Interdisciplinary plan of care.
- The ability of patients to obtain a copy of their EHR.

As the criteria of PI evolve, involvement of nurses as key stakeholders in all phases of the optimization of health information technology is essential (Healthcare Information and Management Systems Society, 2020). In 2015, the Merit-based Incentive Program (MIPS) was passed to address problems that occurred with the PI program. MIPS became effective January 1, 2018. This program changes the rules for PI and how providers must attest their EHR to receive reimbursement for services provided to the patients. MIPS consolidates three existing programs: the Physician Quality Reporting System, the Physician Value-based Payment Modifier, and the Medicare & Medicaid EHR Incentive Program for eligible providers. The focus is on the quality of care provided to patients (CMS, 2021). The combination of PI and MIPS drives incentive programs to require documentation to be completed in the EHR.

IMPLEMENTATION AND EDUCATIONAL REQUIREMENTS

The transition to electronic documentation presents a unique challenge to nurses and nursing education. The successful implementation of a computerized documentation system requires preparation, involvement, and commitment from the entire nursing staff. It also requires thoughtful, deliberate planning as well as recognition of a learning curve. Real-time nursing documentation can provide nurses the opportunity to document patient care data on a tablet at the bedside. The purchase and availability of devices for the nursing staff Is essential. Knowledge of change theory is helpful when implementing new documentation methods. The classic change theory developed by Kurt Lewin is often applied. This model of change requires prior learning to be rejected and replaced. Lewin stated that change occurs in three phases: unfreezing, moving, and refreezing (as cited in Burke, 2017).

During *unfreezing*, a disruption in the balance or equilibrium occurs within the system. Dissatisfaction with current documentation practices provides the need for change. Data regarding the strengths and limitations of the current documentation method should be gathered. During the *moving* phase, a move to a new goal occurs and, because most are uncomfortable with change, resistance also occurs. Development and implementation of new ideas occur as committees are formed, goals are developed, systems are redesigned, and pilot studies are conducted. This phase is the longest in the change cycle.

Finally, in the *refreezing* phase, consolidation and adoption of new ideas occur. Monitoring and evaluation of the changes take place and resource people must be available for user support. As staff members become more comfortable with the new documentation method, acceptance of the method increases and resistance decreases (Lewin, as cited in Burke, 2017)

A plan must be developed to provide the institution a clear understanding of the changes involved in computerized documentation. Implementing a new system requires collaboration and communication among employees of all levels. Establishing goals and time frames keeps the project on target (Bastable, 2017).

Staff development is a critical part of implementing computerized documentation. Staff members must be kept informed about the progress of the change, stages of implementation, and timeline for "going live" with electronic documentation. Their input is necessary to ensure that all questions and concerns are addressed. Institutions must offer specific, detailed classes and provide all staff members the opportunity to attend in-service sessions. Self-learning modules and videos of class presentations are necessary to educate people who are unable to attend classes or for those seeking to review the process leading up to a go-live.

Small-scale pilot projects may be used to implement the new system. Specific units may be selected for the pilot study or all units may go live simultaneously. When transitioning from one system to another, a big-bang go live (all go live at the same

time) may be required rather than maintaining disparate systems. Because of the number of nurses to be trained, education offered occurs weeks or even months before go-live. E-learning modules can assist in keeping knowledge fresh as the live date approaches. Communication and follow-up are key elements in the success of implementation.

The process does not stop at go live. Continued monitoring and evaluation are necessary to determine the degree of compliance of system usage and identify unforeseen problems. Audit of documentation content and timeliness "can be used to identify practice guideline adherence" and can evaluate nursing performance metrics (Karp et al., 2017). Ongoing education, refresher courses, and introduction to new software enhancements help maintain compliance and keep staff up to date (Bastable, 2017).

LEGAL AND SECURITY CONCERNS

The security needs of an electronic documentation method differ from those of handwritten methods. EHRs require additional security measures to ensure reliability and authenticity of user input. Security for EHRs includes the protection of documents, files, systems, and network areas from unauthorized access and damage or loss from fire, water, theft, mutilation, or unauthorized alterations or destruction. Unauthorized access can be obtained in a variety of ways and diligence must be sustained to prevent cyberattacks. One such attack known as ransomware (malicious malware; Jarrett, 2017) takes a system hostage by encrypting files unless money or bitcoin is paid to the attacker. Systems can be down for days or weeks as a result.

Computerized medical records present new challenges to nurses' ethical and legal obligations to safeguard confidential patient information that differ from paper documentation. Security measures must be developed to strictly control the ability of others to access computerized records from distant sites. Even the placement of computer screens must be taken into consideration. Likewise, medical and health records must be protected from destruction by computer viruses introduced via external devices, the Internet, or cyberattacks (Jarrett, 2017). In addition, contingency plans must be in place for other unexpected events, such as natural disasters or the afore- mentioned cyberattacks. A backup system must be in place for recovery of EHRs and to prevent downtime that may disrupt usability (HHS, Office of Inspector General, 2016). Downtime forms must also be available in case manual documentation needs to be implemented and education on their use must be provided to decrease disruption in documentation and patient care

A variety of federal laws protect credit information; however, few laws protect the computerized medical record. The Health Insurance Portability and Accountability Act (HIPPA) regulations require increased security for computers and computer users. With the rapid growth of the Internet, an explosion of high-technology crime and related illegal activities has occurred. Increases in cybercrime have necessitated development of technologies and systems to combat these problems. Breach of security is a very serious concern and users should be given only the level of access necessary to perform their jobs. Most often, use of codes, passwords, fingerprint, or badge scanning are all methods that allow staff to access only information necessary for patient care and preclude access to every patient in the hospital. Hospitals terminate personnel for providing their passwords to unauthorized individuals, and it is a crime to illegally obtain someone's password (Gordon et al., 2017).

The proliferation of EHRs requires a redefinition of specific roles in healthcare, such as records managers and archivists. Plans must be made for the preservation and accessibility of records beyond the useful life of the systems that created them. Decisions regarding storage of electronic records, ease of retrieval, and length of time of record retention must also be made. Electronic data consume much less space than paper records; however, accessibility to records over time requires reproduction of the record in a reliable and authentic format. The length of time for which medical records must be retained varies from state to state. Therefore, when an institution decides to use computerized documentation, all parties involved, as well as legal counsel, must work together to ensure fulfillment of all requirements from every healthcare provider, department, and regulator (Adler, 2021).

FUTURE TRENDS

As the importance of nursing documentation continues to be realized, technology continues to advance to ease the burden of documentation. Voice to text, virtual assistants, and ambient listening (Drees & Dyrda, 2020) are already in use for physicians and will be applied to nursing documentation in the near future. Nursing documentation contributes to the EHR and the big-data initiative. Healthcare big-data has enormous potential for improving health by mining the data with machine learning and artificial intelligence with evidence that outcomes can be improved (Tai, 2020). "It can be used to improve the efficiency and effectiveness of prediction and prevention strategies or of medical interventions, health services, health policies, and even prevent healthcare fraud" (Midha, Ngafeeson, & Ghosh, 2017, p. 95). Big data lays the groundwork for Artificial Intelligence (AI) and genomics, which in turn can offer precision medicine to deliver expert care to a patient. This approximates a learning health system (LHS) that the Health and Medicine Division of The National Academy of Sciences (formerly the Institute of Medicine) has promoted and includes integrated EHRs, the ability for information exchange, and data analysis (Booth et al., 2021).

With the attention to social determinants of health (SDOH), there is a recognized need for understanding the "ethical and social implications of the LHS and for exploring opportunities to ensure that these implications are salient in implementation, practice, and policy efforts" (Platt, 2020). The emergence of telehealth and virtual care (Dress & Dyrda, 2020) may assist in reaching those that are in remote areas without easy access to healthcare. This has also proven to enhance the consumer experience as convenience reigns high as well as access to their own medical records via health portals. New systems are constantly being developed and refined to support a completely computerized medical record. Goals include the development of a computerized system that fully integrates medical records across systems and healthcare organizations and acts as a repository for lifelong medical information.

This should improve the communication between systems throughout the continuum of healthcare. The State Health Information Exchange Cooperation Agreement Program funds states' efforts to rapidly build capacity for exchanging health information across the healthcare system, both within and across states. Health information exchange organizations assist with the interchange of electronic health information across different technologies used for EHRs. The ability of various systems to communicate with one another can have a positive impact on timeliness of receiving patient EHR information in order to treat the patient according to their care needs (Parker, Reeves, Weiner, & Adler- Milstein, 2017).

As technology unfolds, nurses are encouraged to consider the role of EHRs, wearable technologies such as remote monitoring and person generated health data (PGHD), big data and data analytics, and increased patient engagement as key areas to enhance the delivery of patient care.

Conclusion

Each documentation method has its advantages and disadvantages. Institutions, specialty units, and agencies must select the method that works best for their specific needs. The emphasis on measuring outcomes may require many institutions to make changes to their current documentation methods. When a documentation system is being selected, accreditation standards, state and federal regulations, and legalities must be considered. Because healthcare reimbursement fluctuates, with continual changes of supervisory bodies and regulations, new documentation systems must be designed with care. Feedback must be obtained from risk management and legal counsel to ensure the changes are legally sound. Computerized records have increased in popularity over the years and have numerous benefits. EHRs, compared with paper charting, free up physical space in an institution, provide healthcare providers ready access to patient data, and are more legible, which reduces errors. Electronic documentation results in better standardization of care plans and lends to more efficient use of nurses' time. Bedside devices using standard keyboards, touch-sensitive screens, handheld units, palm-sized terminals, voice-activated systems, and other devices now allow nurses to promptly document vital signs, routine care, and changes in status in real time. Implementing electronic medical records as part of a complete electronic patient management program can significantly improve patient safety and ultimately reduce errors.

Glossary

- **algorithm**: Rules or calculations applied for problem solving and clinical decision support.
- **American Nurses Association (ANA)**: Organization of professional nurses in the United States that focuses on standards of healthcare, nurses' professional development, and the economic and general welfare of nurses.
- **(A)PIE charting**: A method of documentation that focuses on assessment, problem, intervention, and evaluation.
- **artificial intelligence**: Computer systems that are able to perform tasks typically requiring human intelligence.
- **block charting**: Method of documentation that covers a broad time frame, frequently a whole shift.
- **breach**: Neglect or failure to fulfill the duties of a job appropriately and properly.
- **care map**: A type of documenting that is based on an integrated treatment plan, identified services, patient outcomes, and length of stay.
- **care plan**: A statement of goals and objectives of nursing care provided for a patient and the interventions required for accomplishing the plan, including the criteria to evaluate the effectiveness and appropriateness of the plan.
- **Centers for Medicare & Medicaid Services (CMS)**: Federal agency that coordinates participation in the federal government's Medicare and Medicaid programs; previously known as the Health Care Financing Administration.
- **certification**: Examination developed by a professional organization that provides verification of a claim to competence at a certain level of practice.
- **charting by exception (CBE)**: A charting method in which data are entered only when there is an exception from what is normal or expected. Reduces time spent documenting.
- **clinical pathway**: A series of sequential steps in a process that is required to ensure a satisfactory out-come.
- **clinical practice guidelines**: The clinical steps for patient management.
- **code of ethics**: A set of values and standards regulating a profession.
- **computerized documentation**: The use of a computer for long-term collection of an individual's healthcare information over a lifetime; the electronic chart used to collect information about a specific patient in a healthcare institution; replacement for manual documentation.
- **confidentiality**: Privacy; a nurse must maintain the confidentiality of information related to a patient's healthcare.
- **critical pathways**: A multidisciplinary care plan through which diagnoses and interventions are sequenced on a timetable.
- **current procedural terminology codes**: Five-digit codes used in billing insurance companies by which services, treatments, and procedures are classified.
- **cyberattack**: Attempt by hackers to disable or destroy a computer system.
- **discharge summary**: Part of a medical record that summarizes a patient's initial complaints, course of treatment, final diagnosis, and suggestions for follow-up care.
- **documentation**: Act of authenticating events or activities by keeping written records.
- **electronic health record (EHR)**: An electronic health record is a digital version of a patient's paper chart. Electronic health records are real-time, patient-centered records that make information available instantly and securely to authorized users.
- **e-MAR**: Electronic Medication Administration listing the medication, amount, route, and time of administration.
- **evaluation**: Category of nursing behavior in which a determination is made and recorded regarding the extent to which a patient's goals have been met.
- **evidence**: Pertinent information surrounding the patient, the scene, or the suspect that might substantiate claims of innocence, guilt, or responsibility for outcomes.
- **evidence-based practice**: A process founded on the collection of, interpretation of, and integration of valid, important, applicable, patient-reported, clinician-observed, research-derived evidence. The best available evidence, moderated by patient circumstances and preferences, is applied to improve the quality of clinical judgments.
- **expert systems**: Broad term encompassing artificial intelligence techniques.
- **flow sheets**: Form of documentation on which frequent observations or specific measurements are recorded.
- **focus charting**: A charting method for structuring progress notes according to the focus of the note, such as symptoms and nursing diagnoses. Each note includes data, actions, and patient response.
- **graphic sheet**: Record of repeated observations and measurements, such as vital signs, daily weight, and intake and output.
- **guidelines**: Recommended nursing practices designed to meet standards of care.
- **healthcare provider**: A member of the multidisciplinary treatment team who renders healthcare to a patient – for example, a physician, an advanced practice registered nurse, or a nursing assistant.
- **Health Insurance Portability and Accountability Act (HIPAA)**: The 1996 act that establishes privacy and security standards to protect patient healthcare information. In December 2000, the U.S. Department of Health and Human Services issued final regulations governing privacy of this information under HIPAA.
- **implementation**: Category of nursing behavior in which the action necessary for achieving projected outcomes of a healthcare plan are initiated and completed.
- **interdisciplinary**: Reliant on the overlapping skills and knowledge of each team member and discipline, resulting in synergistic effects whereby outcomes are enhanced and more comprehensive than the simple aggregation of the team members' individual efforts.
- **interventions**: Part of the nursing process involving all aspects of actual care provided to a patient, which requires full knowledge of the assessment and planning stages.
- **machine learning**: Type of artificial intelligence that analyzes data and enables self-learning
- **medical diagnosis**: Identification of a specific disease or pathologic process.

- **medical record**: Documentation designed to provide a summary of all observations made regarding nursing and medical diagnosis and to accurately reflect measures taken to alleviate identified problems as well as a patient's response to interventions.
- **medication administration record (MAR)**: A record listing the medication, amount, route, and time of administration.
- **minimum data set (MDS)**: A specific form used in long-term care to collect the minimum information needed for assessing a resident's needs to develop a plan of care.
- **multidisciplinary treatment team**: A team of healthcare providers that monitors and determines all aspects of the security, diagnosis, treatment, and rights of a healthcare patient through shared decision making.
- **NANDA International**: Formerly known as North America Nursing Diagnosis Association, an organization involved in developing and promoting the use of nursing diagnoses.
- **narrative notes**: Notes regarding a patient's status written in the nurse's own handwriting that provide an overview of patient care for a shift.
- **natural language processing**: Deciphering of human language into codified data.
- **nursing care plan**: Written guidelines of nursing care that document specific nursing diagnoses, goals, interventions, and projected outcomes for a patient.
- **nursing diagnosis**: A statement that describes a patient's actual or potential response to a health problem that a nurse is licensed and competent to treat.
- **nursing history form**: Data collected about a patient's present level of wellness, changes in life patterns, sociocultural role, and mental and emotional reactions to illness.
- **nursing intervention**: Any action by a nurse that implements the nursing care plan or any specific objective of the plan.
- **nursing process**: Systematic problem-solving method by which nurses individualize care for a patient. The five steps of the nursing process are assessment, diagnosis, planning, implementation, and evaluation.
- **nursing-sensitive indicators**: Indicators that reflect the structure, process, and outcomes of nursing care. Structure indicators measure aspects of the supply, skill level, and education and certification of nursing staff. Process indicators measure aspects of nursing care such as assessment, intervention, and registered nurse job satisfaction. Nursing-sensitive patient outcome indicators (e.g., pressure ulcers, falls, and intravenous infiltrations) are those that improve with a greater quantity or quality of nursing care.
- **objective data**: Data relating to a patient's health problem that are obtained through observation or diagnostic measurement.
- **outcome indicators**: Condition of a patient at the end of treatment, including the degree of wellness and the need for continuing care, medication, support, counseling, or education.
- **patient**: A person who is receiving or has received healthcare, including the deceased.
- **patient medical record**: Written form of communication that permanently documents information relevant to healthcare management.
- **plan of care**: A comprehensive outline of the components of care that need to be addressed to attain expected outcomes.
- **Precision medicine**: Treatment selected for a patient based on their genetic makeup, environment, and lifestyle
- **privacy**: A condition of information about aspects of a person's life over which they claim control and may wish to exclude others from knowing about; may be upheld by laws.
- **problem-oriented medical record**: Method of recording data about the health status of a patient that fosters a collaborative problem-solving approach by all members of the healthcare team.
- **protocol**: A set of rules governing a required process or procedure.
- **reimbursement**: Payment for services rendered to a patient by a third-party payer, such as Medicare, Medicaid, managed care organizations, or insurers; depends on individual fee schedules, laws, and policies of each third-party payer.
- **responsibility**: Carrying out duties associated with a particular role.
- **review of systems (ROS)**: A systematic method for collecting data on all body systems.
- **risk management**: Process used to monitor and improve the quality of healthcare through prevention of injuries by monitoring healthcare equipment and through early, prompt identification of negligent injuries by healthcare providers.
- **scope of practice**: The nursing diagnosis and treatment of human responses to health and illness, defined by the knowledge base of the nurse, the role of the nurse, and the nature of the patient population within the practice environment.
- **SOAP(IER) notes**: A method of charting that documents the subjective findings, objective findings, nursing assessment, and planned nursing interventions. In some cases, interventions, evaluations, and revisions are also included.
- **standard**: Measure or guide that serves as a basis for comparison when evaluating similar phenomena or substances.
- **standardized care plan**: Plan based on an institution's standards of nursing practice that is preprinted; established guidelines used to care for patients who have similar health problems.
- **standards of care**: The minimum level of care accepted to ensure high-quality care of patients.
- **standards of practice**: Serve as the framework for statements about competency levels and form the basis for outcomes for education and standards for the delivery of nursing care.
- **standing orders**: Written and approved document containing rules, policies, procedures, regulations, and orders for the conduct of patient care in various stipulated clinical settings.
- **subjective data**: Data relating to a patient's health problem described in the patient's own words.
- **telehealth**: The provision of healthcare remotely by means of telecommunications technology. May also be referred to as virtual care.
- **The Joint Commission**: A not-for-profit, independent organization dedicated to improving the quality of healthcare in organized healthcare settings.
- **timely documentation**: Documentation that is recorded shortly after observation, intervention, or evaluation of a patient.
- **triage**: A process by which a group of patients is sorted according to their needs for care. The kind of illness or injury, the severity of the problem, and the facilities available govern the process.
- **twenty-four-hour patient care record**: A documentation method that consolidates the nursing record into a system that accommodates a 24-hour period.
- **U.S. Department of Health and Human Services (HHS)**: The federal agency in charge of Medicaid and Medicare programs.
- **variance**: An event that occurs during patient care and that differs from what is predicted. Variances or exceptions are interventions or outcomes that are not achieved as anticipated. Variance may be positive or negative.

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DOCUMENTATION IN THE ELECTRONIC AGE FOR NURSES

Self-Assessment Answers and Rationales

1. The correct answer is A.
Rationale: Vital signs are discrete data that can be trended and/or graphed.

2. The correct answer is C.
Rationale: Charting by exception assumes that only findings that are out of the normal range are documented.

3. The correct answer is D.
Rationale: Following a concussion, tolerance of activity and pain management are monitored. Patient education and discharge instruction are all part of the plan of care.

4. The correct answer is C.
Rationale: Documentation of medication administration is required for all patients regardless of method of documentation.

5. The correct answer is A.
Rationale: Clinical decision support with eMAR and BMV revealed a potential wrong dose, need for recording of the pain scale and reassessment.

6. The correct answer is D.
Rationale: The online medication administration record can be viewed on any device and presents with medication times due and medications times given. Documented data can be trended.

7. The correct answer is C.
Rationale: Clinical decision support can prompt the user of required information or provide available information to assist in decision making.

8. The correct answer is B.
Rationale: While reflex ordering does add value by eliminating the need to order additional tests, ordering is not considered documentation.

9. The correct answer is D.
Rationale: Each of these can eliminate the need for redundant or duplicative documentation.

10. The correct answer is B.
Rationale: When documenting a patient's own words, it is important to do this verbatim and include in a narrative note.

Management of Anxiety and Depression for Healthcare Professionals

3 Contact Hours

Release Date: July 28, 2021

Expiration Date: July 28, 2024

Faculty

Karen S. Ward, PhD, MSN, RN, COI, received BSN and MSN degrees in psychiatric-mental health nursing from Vanderbilt University and a PhD in developmental psychology from Cornell University. She is a professor at the Middle Tennessee State University School of Nursing, where she has taught in both the undergraduate and graduate programs. Dr. Ward's work has been published in journals such as Nurse Educator, Journal of Nursing Scholarship, Journal of Emotional Abuse, and Critical Care Nursing Clinics of North America. She has also presented her work at local, regional, and international conferences. Dr. Ward's research interests include child and adolescent maltreatment, mental health, and wellness issues (stress and depression), leadership variables, and survivorship.

Karen S. Ward has disclosed that she has no significant financial or other conflicts of interest pertaining to this course.

Debra Rose Wilson, PhD, MSN, RN, IBCLC, AHN-BC, CHT, received an MSN in holistic nursing from Tennessee State University School of Nursing and a PhD in health psychology with a focus in psychoneuroimmunology from Walden University. She has expertise in public health, psychiatric nursing, wellness, and disease prevention. In addition to being a researcher, Dr. Wilson has been editor of the International Journal of Childbirth Education since 2011 and has more than 150 publications with expertise in holistic nursing, psychoneuroimmunology, and grief counseling. Dr. Wilson has a private practice as a holistic nurse and is an internationally known speaker on stress and self-care. Dr. Wilson was named the 2017-2018 American Holistic Nurse of the Year. She is on the faculty at both Austin Peay State University School of Nursing and at Walden University.

Debra Rose Wilson has disclosed that she has no significant financial or other conflicts of interest pertaining to this course.

Reviewer: Cindy Parsons, DNP, ARNP, BC, is a Psychiatric Mental Health Nurse Practitioner and educator. She earned her Doctor of Nursing Practice at Rush University, Illinois and her Nurse Practitioner preparation from Pace University, New York. Dr. Parson's is an Associate Professor of Nursing at the University of Tampa and maintains a part-time private practice. She is board certified as Family Psychiatric Nurse Practitioner and a Child and Adolescent Psychiatric Clinical Specialist and her areas of specialization are full spectrum psychiatric mental healthcare with a focus on family systems, community health and quality improvement. Dr. Parson's currently serves as the chair of the QUIN council, is the membership chair for the Florida Nurse Practitioner Network, and in 2009, she was inducted as a Fellow of the American Association of Nurse Practitioners.

Cindy Parsons has disclosed that she has no significant financial or other conflicts of interest pertaining to this course.

Course overview

Mood disorders are common and often mistreated. The purpose of this course is to help healthcare workers in their treatment of patients with mood disorders such as anxiety, depression, and bipolar disorder, and to provide patients with access to treatment options. The treatment of mood disorders includes therapy and medication. This course helps to prepare healthcare professionals to differentiate the various mood disorders patients are exhibiting and their causes, identify risk factors for these disorders, recommend treatment options, provide a calm and supportive environment for patients, explore holistic considerations, and use evidence-based complementary therapies to assist patients.

Learning objectives

Upon completion of this course, the learner will be able to:

- Examine the possible causes and precipitating events of anxiety in patients.
- Evaluate the different levels of anxiety in patients.
- Apply evidence-based healthcare interventions for patients with anxiety.
- Differentiate the theories of causation and risk factors associated with depressive and bipolar disorders.
- Implement healthcare interventions commonly used with patients experiencing depressive and bipolar disorders.

How to receive credit

- Read the entire course online or in print which requires a 3-hour commitment of time.
- Complete the self-assessment quiz questions which are at the end of the course or integrated throughout the course. These questions are NOT GRADED. The correct answer is shown after you answer the question. If the incorrect answer is selected, the rationale for the correct answer is provided. These questions help to affirm what you have learned from the course.
- Depending on your state requirements you will be asked to complete either:
  - An affirmation that you have completed the educational activity.
  - A mandatory test (a passing score of 70 percent is required). Test questions link content to learning objectives as a method to enhance individualized learning and material retention.
- If requested, provide required personal information and payment information.
- Complete the MANDATORY Course Evaluation.
- Print your Certificate of Completion.

CE Broker reporting

Colibri Healthcare, LLC, provider # 50-4007, reports course completion results within 1 business day to CE Broker. If you are licensed in Arkansas, District of Columbia, Florida, Georgia, Kentucky, Michigan, Mississippi, New Mexico, North Dakota, South Carolina, or West Virginia, your successful completion results will be automatically reported for you.

Accreditations and approvals

Colibri Healthcare, LLC is accredited as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation.

Individual state nursing approvals

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Disclosures

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INTRODUCTION

It is common for patients to experience some anxiety about their health status. The need for hospitalization creates stress for everyone. Each patient experiences anxiety and responds to it uniquely. When patients have difficulty coping with their level of anxiety, certain strategies can help them reduce it by maximizing their coping abilities and using other stress reduction techniques (Halter, 2018; Townsend & Morgan, 2017). Both psychological and physical stress can precipitate feelings of anxiety. These feelings may be coped with in a variety of ways, or they may be overwhelming. When they are overwhelming, the person's coping mechanisms may be insufficient to manage the anxiety.

Depressive and bipolar disorders are general categories for illnesses that influence behavior, mood, and thoughts and are classified as mood disorders. They affect the way people eat and sleep, the way people feel about themselves, and how they think. Mood disorders are considered relatively common (Halter, 2018). Although almost everyone has periods of sadness and joy, people who have experienced major depression, such as bipolar, know that it is much more than "the blues." For people with bipolar, the other end of the spectrum, known as mania, is more than just being really happy. These disorders can be detrimental to patients and often are treated with therapy and medication.

Healthcare Professional Consideration: Healthcare professionals who are not used to dealing with patients experiencing high levels of anxiety may begin to feel anxious themselves as they interact with these individuals. In fact, the healthcare professional may become anxious simply as a result of trying to calm an extremely anxious patient. If this begins to happen, remembering that interaction with a patient who is anxious can cause anxiety symptoms is helpful. If that does not work, asking another clinician to care for the patient for a while is prudent behavior. If the healthcare professional is anxious, the patient will sense the healthcare professional's anxiety, and the situation will escalate. Healthcare professionals should feel comfortable asking for help from one another when caring for patients with anxiety (Rasheed et al., 2019).

CAUSES AND PRECIPITATING EVENTS OF ANXIETY

Almost everyone experiences dread and fear of the unknown at one time or another. Often the specific cause of anxiety and the precipitating events that lead to it may be unclear or unknown. Anxiety is generally related to situational, maturational, or other factors related to the patient's basic needs for food, air, comfort, and security. When these feelings escalate, the individual often experiences moderate or higher levels of anxiety.

As people go through maturational stages and their required role changes as part of normal growth and development, psychological disequilibrium can occur. Adolescence, marriage, parenthood, career changes, and retirement are examples of maturational turning points that might trigger a crisis (American Psychological Association, 2016).

Changes to a person's status are generally perceived as stressful. The event can be negative (an illness) or positive (the 1st day at a new job). These events and feelings may culminate in a crisis when a person's normal coping mechanisms fail, and they can no longer cope effectively with day-to-day tasks (Halter, 2018; Townsend & Morgan, 2017).

Situational crises may be related to a specific external event that causes the loss of a person's psychological equilibrium. Examples are the death of a significant other, divorce, school problems, and illnesses. A hospital admission is a stressful event in most cases and can often cause a crisis (International Society of Psychiatric-Mental Healthcare professionals, 2020). The precipitating stressors are different for each person. Having an illness diagnosed or being injured can provoke an identity crisis. In addition to coping with the fear of the disease or injury itself, people who are ill or injured may have to change their views of themselves.

Healthcare Professional Consideration: If a patient is having difficulty dealing with stressful situations and anxiety begins to be a common symptom, there are many coping strategies that the healthcare professional might suggest. Physical activity, particularly in the form of a regular exercise program, is helpful for stress management and provides significant health benefits. Walking, swimming, yoga, and biking are a few examples of activities that require movement. Patients should be encouraged to find something they enjoy and can continue with on a regular basis. Hobbies are also useful in combating stress. Regular participation in activities such as baking, photography, art of various kinds, scrapbooking, gardening, and many more all provide relaxation and a time to focus on something the person enjoys. Many times, there are community groups made up of people who are all interested in the same hobby. Attending meetings with like-minded people provides socialization, which can also benefit someone who is anxious.

Evidence-based practice! Just by surfing the Web, individuals can research and learn about their health conditions without consulting any healthcare provider. Researchers wondered if these Web searches were beneficial or harmful (Brown et al., 2019). Their findings were dependent on the individuals and how high their "health anxiety" was. For some people with high health anxiety, looking on the Internet caused an increase in anxiety. For others, anxiety was lowered as a result of the search. Another factor the researchers considered was how easy it was for the individuals to access their personal healthcare providers. Those with easy access were less likely to have increased anxiety after an Internet search. These findings point out how important it is to help healthcare consumers understand which sites are reliable and how best to use the information available.

LEVELS OF ANXIETY

How anxiety affects a person's abilities varies with the level of anxiety experienced (Table 1). Four levels of anxiety are generally recognized (Halter, 2018; Townsend & Morgan, 2017). They range from mild anxiety to panic. Some anxiety is good for people because it serves to motivate them to action. When patients experience mild anxiety, their perception and attention are heightened, and they can learn. However, if patients' anxiety is at the panic level, they cannot learn and are unable to function (American Psychological Association, 2016). High levels of anxiety in patients may also cause anxiety in healthcare professionals (See Table 1).

Table 1. Levels of Anxiety

Level of anxiety	Changes in cognition, perception, and tension	Effects on learning
1. Mild	• Seemingly heightened sensory input • Increased alertness • Attentive • Slight muscle tension	• Logical problem-solving skills • Able to achieve and succeed in specific tasks • Can solve problem that is causing anxiety
2. Moderate	• Narrowed perception • Misperception of stimuli • Reduced ability to communicate • Difficulty in concentrating • Increased nervousness and tension • Moderate muscle tension • Increased pulse, blood pressure, and respiration	• Some coping skills are still functional • Can follow directions • With some help, the anxiety can be dealt with successfully
3. Severe	• Narrowed perceptual field • Distorted perceptions • Disoriented • Focused on the short term • Shortened attention span • Physical discomfort, if present, adding to a sense of emotional discomfort • Delusions with hallucinations if anxiety is prolonged • Extreme muscle tension	• Ineffective reasoning • Ineffective problem-solving skills • Difficulty focusing on problem solving even with assistance

Table 1. Levels of Anxiety (continued)		
Level of anxiety	**Changes in cognition, perception, and tension**	**Effects on learning**
4. Panic	• Disorganized perceptions • Feelings of being overwhelmed, being out of control, and terror • Unfocused, random, fleeting, irrational, and incoherent thoughts • Severe cognitive impairment	• Inability to learn • Disorganized or irrational reasoning or problem solving • Difficulty with minimal functioning • Unable to reduce anxiety or solve the problem • Cannot function at this level for long periods

Levels of Anxiety. (2021). The Recovery Village Drug and Alcohol Rehab. https://www.therecoveryvillage.com/mental-health/anxiety/related/levels-of-anxiety/

Box 3-1. Anxiety Is Contagious

Healthcare professionals who are not used to dealing with patients who are experiencing high levels of anxiety may begin to feel anxious themselves as they interact with these individuals. In fact, the healthcare professional may become anxious simply as a result of trying to calm an extremely anxious patient. If this begins to happen, remembering that interaction with a patient who is anxious can cause anxiety symptoms is helpful. If that does not work, asking another clinician to care for the patient for a while is prudent behavior. If the healthcare professional is anxious, the patient will sense the healthcare professional's anxiety, and the situation will escalate. Healthcare professionals should feel comfortable asking help from one another when caring for patients with anxiety.

Anxiety Is Contagious. Here's How to Contain It. (2021). Harvard Business Review. https://hbr.org/2020/03/anxiety-is-contagious-heres-how-to-contain-it

It is important for healthcare professionals to accurately assess their patients' anxiety levels, respond accordingly (Halter, 2018; Townsend & Morgan, 2017), and understand that there are effective treatment options (Anxiety and Depression Association of America, 2016).

Case study 1

Judy Norris, a 45-year-old woman, came to the outpatient clinic complaining of difficulty breathing and feeling incredibly nervous. She said her nerves were out of control and that she needed help immediately. When the healthcare professional began the preliminary interview, she asked Judy if there was anything different happening in her life at this time. Judy said she wanted treatment right away because she had a job interview the next day and did not want to mess it up.

Self-Assessment Quiz Question #1

Which response by the healthcare professional would be the most therapeutic?

a. "It sounds like this interview must be very important to you."
b. "Where is your interview?"
c. "Oh, I don't think you will mess it up."
d. "Perhaps the physician can prescribe something to help you."

Case study 2

Judy tells the healthcare professional that it is an important interview for her. It is with a larger company than she currently works for. Her responsibilities would be expanded, and her pay would be significantly higher. The best part about this potential new job to Judy is that she could really use all of her skills in a meaningful way; she calls it her dream job. As she talks about the job, the healthcare professional notices that Judy has already calmed down significantly. She is able to communicate her thoughts in a coherent fashion, and she is having no difficulty breathing.

Self-Assessment Quiz Question #2

What level of anxiety is Judy experiencing while talking to the healthcare professional?

a. Mild.
b. Moderate.
c. Severe.
d. Panic.

PHYSIOLOGICAL RESPONSES

In addition to the many emotional changes that happen when a person is feeling anxious, several physical signs and symptoms may occur. As an individual begins to experience anxiety, the body starts a process commonly known as "fight or flight." Hormonal responses are stimulated to provide protection to the individual by physiologically programming the body to give priority to those functions that are the most necessary. Briefly, the hypothalamus sends adrenocorticotrophin-releasing hormones to the pituitary gland, which in turn secretes adrenocorticotropic hormones. From there, adrenaline and cortisol are released by the adrenal and sub adrenal glands. The physical effects that individuals with anxiety experience are the result of the accelerated production of these hormones on the body (Jameson, 2016). These effects are generally negative and may include the following:

- Abdominal distress
- Chest pain or discomfort
- Choking or smothering sensations
- Cold, icy hands
- Diaphoresis
- Dizziness
- Dry mouth
- Dyspnea
- Elevated blood pressure
- Faintness
- Frequent urination
- Headaches

- Increased respiratory rate
- Insomnia
- Nausea
- Palpitations
- Queasiness
- Restlessness
- Tachypnea
- Trembling
- Voice tremors

Case study 3

Penny, a healthcare supervisor for a large hospital unit, had a discussion with Anna, the head of continuing education at the hospital, about why the staff seemed to pay little attention during in-services and had mediocre performance on the final testing. Although coming to the in-service itself was mandatory, the healthcare professionals received credit for attending regardless of their final test scores, as long as they turned in a testing form.

Self-Assessment Quiz Question #3

What level of anxiety are the staff healthcare professionals most likely experiencing regarding their mandatory in-services and the tests?

a. Mild.
b. Moderate.
c. Severe.
d. None.

Case study 4

Both Penny and Anna agreed that there should be some consequence attached to the test performance at the in-services, if only to motivate the staff to pay closer attention and to do better on the tests.

Self-Assessment Quiz Question #4

What anxiety level would Penny and Anna want to see in the healthcare professionals attending the in-service?

a. Mild.
b. Moderate.
c. Severe.
d. Panic.

DIAGNOSTIC ASSESSMENT

The following are the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5) diagnoses and the North American Healthcare Diagnosis Association (NANDA) healthcare diagnoses that might be applicable to patients with emotional or psychological issues related to anxiety. Of course, circumstances may warrant additions to the list of diagnoses for any specific patient, but those listed here are likely for anyone experiencing anxiety symptoms or disorders.

DSM-5 psychiatric diagnoses

The psychiatric disorders generally associated with anxiety are as follows (American Psychiatric Association, 2013):

- Specific phobia (marked fear or anxiety about a specific object or situation)
- Generalized anxiety disorder (symptoms of anxiety present for at least 6 months with extensive worry but without panic attacks)
- Panic disorder (repeated experiences of terror, feelings of impending death, inability to breathe comfortably), with or without agoraphobia (marked fear or anxiety of being in open spaces or enclosed places)
- Substance/medication-induced anxiety disorder (symptoms of panic attacks or anxiety develop during or soon after a substance intoxication or withdrawal or after exposure to a medication)

NANDA healthcare diagnoses

The possible NANDA healthcare diagnoses may include one or more of the following (Herdman & Kamitsuru, 2018):

- Anxiety (e.g., mild, moderate, severe, panic)
- Decisional conflict
- Deficient knowledge
- Confusion (e.g., acute, chronic)
- Coping (e.g., ineffective, readiness for enhanced, compromised family, defensive)
- Fear
- Ineffective coping
- Impaired memory
- Post-trauma syndrome or risk
- Powerlessness
- Ineffective role performance
- Health-seeking behavior
- Self-care deficit
- Self-esteem (e.g., chronic low, situational low, risk for low)
- Disturbed sleep pattern
- Impaired Social interaction
- Social isolation
- Spiritual distress, risk; readiness for

HEALTHCARE INTERVENTIONS

Healthcare professionals can help patients cope effectively with mild or moderate anxiety by having them use (a) strategies that have been helpful in the past and (b) other problem-solving methods as needed. Patients who are experiencing severe anxiety or panic need help coping and reducing their level of anxiety so that their problem-solving abilities can be effective. It is important for the healthcare professional to remain calm.

Possible healthcare interventions (along with their rationales) that may be appropriate for patients who are experiencing anxiety are listed in Table 2.

Table 2. Healthcare Interventions and Rationale for Patients Who Are Experiencing Anxiety	
Healthcare Intervention	**Rationale**
Establish trust, maintain a calm demeanor, and be nonthreatening.	To be effective with healthcare interventions, establish a trusting relationship with the patient. Additionally, it is well known that anxiety is contagious. A patient's anxiety can affect the healthcare professional and other staff members and vice versa. Maintain a calm demeanor to comfort the patient.
Reassure patients of their safety and security. Staying with the patients, just by being there, can provide comfort.	Patients may be experiencing a threat to their physical well-being or self-concept.
Communicate in a calm and clear manner with a succinct message and simple language, particularly when the patients have a high level of anxiety.	When their anxiety levels are high, patients may be unable to comprehend at their usual level of awareness.
Explore the patients' perception of harm and assess the actual potential danger.	Clarifying the reality of the situation and assisting with the patients' coping mechanisms can reduce the patients' anxiety level.
Decrease external stimuli by dimming lights, lowering background noise, and limiting the number and frequency of visitors.	External stimuli can increase anxiety levels.
Encourage verbalization.	By talking through some events and precipitating factors, patients can • gain insight into the precipitating factor, • gain insight into their manner of coping with the anxiety itself, • enact new strategies for coping, and • verbalize the problem.
Assist patients with skills they currently cannot use because of their anxiety.	When anxiety is especially high, usual tasks are more difficult, and learning new tasks is harder.
When the patients' anxiety level has been reduced, explore the precipitating events that led to anxiety.	A recurrence of anxiety may be prevented or reduced in severity when the patients can recognize its early signs and begin using strategies to reduce it.
Teach patients to identify and describe feelings of anxiety.	When patients understand their experience of anxiety, they can • recognize the early signs and symptoms, • perhaps reduce the level of or thwart the episode, and • be receptive to adopting new coping responses.
Demonstrate and review available anxiety-reducing techniques, and help patients choose techniques and strategies to reduce their anxiety levels. These include • relaxation techniques (e.g., breathing techniques, visualization, muscle tension reduction), • physical exercise, • meditation and yoga, • occupational activity, and • diversional activity.	By reducing the level of anxiety, restoration of homeostasis is more obtainable.
Include the patient in setting goals and planning care.	Allowing patients a choice increases their chances of success, their independence, and, therefore, their self-esteem.
Administer anxiolytic medications as prescribed, assess the need for medications to be given as needed, assess the effectiveness of the drug, and monitor the patient for potential adverse side effects.	Antianxiety medications prescribed for short-term use can reduce the patients' anxiety.
Teach the patients about the self-administration of anxiolytic medications.	The patients may benefit from anxiolytic medications and then continue taking them as outpatients.
Assess the patients' mood and observe for signs of depression and any possible suicidal ideation. If present, notify the patients' physician and refer for ongoing psychiatric treatment.	Severe anxiety can coexist with depression.
Teach the importance of sleep.	Sleep deprivation reduces the ability to cope with anxiety.
Encourage the patients to reduce caffeine intake.	Caffeine intake can induce higher levels of anxiety because it potentiates the fight-or-flight response, increasing heart rate, dilating pupils, and increasing feelings of jitteriness.
Teach strategies to quit smoking.	Having a cigarette may reduce the sense of anxiety for a short time, but this is because withdrawal symptoms are briefly quieted. Nicotine has anxiety-producing qualities.
National Center for Complementary and Integrative Health [NCCIH], 2016	

Table 3. Part of a Care Plan for a Patient with Anxiety	
Problem / Healthcare Diagnoses	The patient has anxiety related to change in body image as evidenced by tension, verbalized, and demonstrated helplessness, verbalized fear, uncertainty, expressed concerns, grimacing, perspiration, sobbing, and irrational behavior (e.g., pulling at intravenous line, shouting).
Treatment Plan / Approaches	1. Assess level of anxiety. 2. Establish therapeutic relationship. 3. Offer appropriate interventions on the basis of level of anxiety. ● Mild anxiety: Listen to the patient and redirect activities. ● Moderate anxiety: ○ Consider as-needed medications if prescribed. ○ Offer a choice between two things. ○ Try to decrease stimuli. ○ Offer an opportunity for physical activity. ○ Use a matter-of-fact approach. ● Severe anxiety: Ask a patient-care technician to stay with the patient or check on the patient often. 4. Help the patient recognize feelings and describe what preceded them. If possible, connect the feeling to the unmet need; describe the patient's behavior and connect it to the anxiety.
Colibri Healthcare, LLC, 2021.	

Healthcare Professional Consideration: Sometimes a patient is extremely anxious and unable to communicate successfully with a healthcare professional who is sitting and trying to have a face-to-face discussion. Such a situation might warrant trying an unconventional approach. One possibility is to try working a puzzle together. There are several reasons this might work:

1. Some silence would be expected while both parties are concentrating on finding pieces to the puzzle.
2. Conversation can initially be confined to comments about the puzzle itself.
3. The patient can be reinforced when a piece is successfully placed.
4. Verbal exchanges are nonthreatening as there is no eye contact because the healthcare professional and patient are both looking at the puzzle.

HOLISTIC CONSIDERATIONS

Today's healthcare professionals are encouraged to use evidence-based complementary therapies in the care of patients with anxiety. Guided imagery is a tool that healthcare professionals can use to assist patients who are anxious (National Center for Complementary and Integrative Health [NCCIH], 2016). Guided imagery involves using mental images to calm oneself, reduce the stress response, reduce pain, or blood pressure, and promote sleep. This relaxing visualization has been found to enhance healing and physical health in numerous studies. The power of the mind over biology is studied in the field of psychoneuroimmunology and is relevant to many disciplines besides healthcare; for example, athletes who use visualization techniques are known to improve performance. Psychologists teach patients these techniques to reduce panic attacks or phobic reactions. However, guided imagery is not recommended for people who are hallucinating or any break with reality (NCCIH, 2017).

To use guided imagery with a patient, the healthcare professional should ask the patient to recall a calm and safe place. Instructing the patient to begin with some slow breaths and lower or close their eyes, the healthcare professional should guide the patient to breathe mindfully. In a calming voice, the healthcare professional should describe what the patient might see, feel, smell, taste, or hear in this environment. With attention to each of the senses, it is easier for the patient to experience and remember that safe, calm place and begin to relax. Guided imagery scripts and recordings are available online to assist the healthcare professional in gaining competence with this practice.

Evidence-based practice! Many researchers are attempting to find scientific support for the use of alternative and complementary therapies. One area that has received a great deal of interest is in the use of aromatherapy. Essential oils have been used throughout history and in many different cultures to relieve pain, promote sleep, and reduce anxiety. Until recently, there was little evidence to support their use. A study conducted by a team of researchers (Lindgren, 2019) in a community magnet hospital was able to provide support for the use of essential oils in helping patients with anxiety and pain. It found that treating patients with a combination of essential oils (frankincense, blue cypress, lavender, and melaleuca) reduced anxiety and pain more than just the administration of medications. Such findings will assist with treatment planning for patients with anxiety.

Case study 5

Roberto Torres is a 22-year-old male patient who was admitted to the orthopedic unit of a general hospital with a fractured femur, an injury that occurred while he was playing football. It is the first time he has had a serious injury. Roberto recently had surgery to treat his injury, and his left leg is in a cast. He has an intravenous line and a urinary catheter in place. He is a big man and seems uncomfortable being confined to the hospital bed. He has a prescription for pain medication that does not seem to be meeting his needs for pain relief. The night healthcare professional reported that Roberto slept poorly and complained often.

Twenty-four hours after Roberto's surgery, his healthcare professional, Katrina Park, notices that he is extremely restless. He calls for Katrina often because of minor complaints and seems to want a healthcare professional to attend to him constantly.

When Katrina answers Roberto's call light once again, she finds him crying and difficult to console. She approaches him, and he startles her by jumping upright in the bed, pulling at his intravenous line, and shouting some obscenities. Then he yells, "You just don't get it! This is driving me crazy!"

Self-Assessment Quiz Question #5

What level of anxiety is Roberto experiencing at this point?

a. Mild.
b. Moderate.
c. Severe.
d. Panic.

DEPRESSIVE AND BIPOLAR DISORDERS

Depressive and bipolar disorders are general categories for illnesses that influence behavior, mood, and thoughts and are classified as mood disorders. They affect the way people eat and sleep, the way people feel about themselves, and the way people think. According to the American Psychiatric Association's (2013) Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5), these disorders may be characterized by (a) sadness, social withdrawal, guilt, and the expression of self-deprecating thoughts (depressive symptoms); (b) an elevated, expansive mood that includes hyperactivity, pressured speech, decreased need for sleep, poor judgment, and impaired impulse control, lasting most of the day every day for at least a week (mania); or (c) a combination of both. On either end of a continuum, from a mood so "up" that normal social and economic boundaries are forgotten to one so "down" that an individual is at risk for suicide, mood disorders include a spectrum of diagnostic categories and varying degrees of risk to the individual.

A specific diagnosis and appropriate interventions are naturally dependent on what the patient reports. The severity of the symptoms influences the determination of a diagnosis, the patient's desire for treatment, and the risk for suicide. Although patients often seek help during the depressive episode of a bipolar disorder, they frequently do not recognize that the times of high energy and excessive behavior are problematic. Specific criteria for these disorders are listed in the DSM-5. North American Healthcare Diagnosis Association (NANDA) healthcare diagnoses also vary for these illnesses, depending on the particular situation and symptom presentation (Herdman & Kamitsuru, 2018). Learning to recognize the symptoms and conduct a risk assessment for patients experiencing mood disorders is important for healthcare professionals in all healthcare settings.

PREVALENCE

Given the many different ways mood disorders can manifest in individuals experiencing them, they are considered relatively common (Halter, 2018). Although almost everyone has periods of sadness and joy, people who have experienced major depression know that it is much more than "the blues." At the other end of the spectrum, mania is more than just being really happy. Because of its frequency and potential risk to life, depression is often discussed as part of news coverage in the media or through storylines on popular television shows, and it is featured in advertisements for antidepressant medications. Because patients may exhibit any of the potential behavioral patterns, healthcare professionals should be aware of the other types of mood alterations as well.

Depression is poorly recognized and underdiagnosed. It is among the most treatable of psychiatric illnesses, with estimates that as many as 80% (and possibly more) of depressed patients respond positively to treatment consisting of "talk" therapy, antidepressants, or a combination of these (Mayo Clinic, 2018b). Depression is the most common mental disorder in the United States (National Institute of Mental Health [NIMH], 2019). However, depression is often mistakenly labeled as some other condition and therefore is not treated appropriately.

When patients describe their situation with words such as "sad," "hopeless," "nothing to live for," and "despair," they are indicating depression on some level. The healthcare professional should be alert for other assessment data that can confirm a mood disorder. Major depressive disorder is an alteration in mood – a disturbance in a person's feelings marked chiefly by sadness, apathy, and loss of energy – that makes it almost impossible to carry on usual activities, sleep, eat, or enjoy life (National Institute of Mental Health, 2016). Correct diagnosis is critical to initiating appropriate treatment and preventing the patient from sinking deeper into depression and, perhaps, attempting suicide.

Healthcare Professional Consideration: While conducting an initial assessment of a patient, intake healthcare professionals may become unusually tired and worn out and begin to feel that they cannot wait to get out of the room of this particular patient. Highly likely, this is a depressed patient. Taking care of patients who are depressed is often frustrating, stress-evoking, and tiring for the healthcare professional. Even if the patient has not described feeling depressed, the healthcare professional should ask the patient about it. Healthcare professionals must learn to trust their intuition when caring for a patient who is depressed. The holistic healthcare professional becomes intentionally self-aware and examines how caring for patients affects the self.

NIMH » Depression. (2021, July 23). NIMH. https://www.nimh.nih.gov/health/publications/depression/?NIMH+symptoms+of+depression=

Self-Assessment Quiz Question #6

A healthcare professional finds herself uncharacteristically snapping at a coworker. The healthcare professional should:

a. Take a deep breath and keep going.
b. Realize it is the coworker's fault.
c. Be mindful of her present mood and examine what might have triggered it.
d. Think mindfully about it before she goes to sleep that night.

Suicide is a serious problem and its connection with depression is strong; all depressed patients should be assessed for suicidal ideation. Contrary to common myth, asking a person if they are considering suicide will not put the idea into their head. If the healthcare professional suspects that a patient is contemplating taking their life, a thorough assessment needs to take place immediately.

Depression is a biological illness affecting individuals all over the world. It is a leading cause of disability in the United States and many other developed countries (Mayo Clinic, 2018b), although rates are often difficult to determine because of underdiagnosed and misdiagnosed cases. A depressive episode can occur once in a lifetime, or, as with many people, depression can recur several times. The most serious consequence of depression is

suicide, but there are many other consequences that influence social connections, general health, and well-being.

In the United States, 7.1% of all adults are diagnosed with depression, but many do not seek diagnosis and treatment. The prevalence of depression has not increased significantly since 2001 in the United States. Only 34.17% of persons with severe depression were diagnosed by a health professional. Although more people are receiving medical diagnosis and treatment than previously, symptoms reported remain severe, even with treatment (Mental Health America, 2017). Major depression affected an estimated 16 to 19 million adults aged 18 or older in the United States who had reported at least one major depressive episode in the past 12 months (Mental Health America, 2017; Substance Abuse and Mental Health Services Administration, 2020).

Depression is common in older adults and often goes undiagnosed. In fact, depression is the most common mood disorder in older adults. Estimates of depression among those older than 65 years range from 5% to 20% and perhaps higher (Centers for Disease Control and Prevention [CDC], 2016b; Mental Health America, 2017; NIMH, 2017). Depression is not part of normal aging. Older adults are at increased risk because they often have other chronic health conditions or are taking medications that contribute to the incidence of depression (Mental Health America, 2017; NIMH, 2017). Treatment for depression in older adults is often overlooked because of the false belief that depression is normal. Healthcare professionals should screen older adult patients for depression. If an older adult makes the decision to commit suicide, the rate of successful suicide on first attempt is much higher than in other age groups (Mental Health America, 2017).

Depression and suicide are also growing problems among youth. According to 2017 data, depression (low level and major depression) has been diagnosed in approximately 11.2% of 13- to 18-year-old adolescents in the United States (Child Stats .gov, 2020). Teenage girls have higher rates of depression than boys (Mental Health America, 2017). It is estimated that between 3.3% and 11% of the adolescent population has been diagnosed with major depressive disorder (NIMH, 2017). Suicide is now the leading cause of death for the 10- to 34-year age group (NIMH, 2021).

Younger children (aged 12 years and younger) can also be diagnosed with depression, and the rates of depression in undiagnosed children are not known. It is estimated that approximately 5% of young children suffer from depression, although most are undiagnosed (American Academy of Child and Adolescent Psychiatry, 2018). Healthcare professionals should be especially alert for signs of depression in young children, knowing that they may not be as easily diagnosed. Obesity in children is on the rise and is associated with higher rates of depression (Ogden et al., 2016). Even young children are not immune to the potential for major depression.

Bipolar disorder (formerly known as manic depressive illness) is characterized by an alternating pattern of emotional highs (mania) and lows (depression); the disorder can range from mild to severe. An epidemiological study in 2005 estimated that 3% to 5% of the population has bipolar disorder (NIMH, 2017). It often begins in adolescence or early adulthood and may persist for life. Although it is not nearly as common as depression, bipolar disorder can also have life-altering effects. For example, in the manic phase, patients can deplete their life savings; then, as they plunge into depression, suicide becomes a risk. There may or may not be periods of normalcy that provide relief from this cyclical disorder. The cycles from mania to depression often become more rapid as the disease progresses. As with depression, bipolar disorder is seen in all age groups and appears more severe for younger patients. As with all mental health problems, early diagnosis, effective treatment, and careful monitoring are extremely helpful.

THEORIES ON CAUSATION

Different investigators have different opinions about the causes of depressive and bipolar disorders. There is no doubt, based on the past decade of research, that depression and bipolar illness are brain-based disorders caused by complex interactions between many biochemical, genetic, cognitive, behavioral, and environmental sources that affect people from all ages, races, and ethnicities (Depression and Bipolar Support Alliance, 2020). Some psychosocial and biological theories describe the more widely known and accepted causes of depression.

Psychosocial theories

The psychodynamic or psychoanalytic view of depression is that a loss or lack of love when the depressed person was a young child caused conflicting feelings and grief. When these feelings go unresolved, the result may be rage, hostility, bad mood, and anger turned inward. Thus, the person becomes depressed (American Psychoanalytic Association, n.d.).

Cognitive theory suggests that depressive feelings result from faulty thinking, ideas, and beliefs; a distorted view of others; and low self-esteem. When the person's thinking or cognition is corrected through cognitive therapy, the depression is alleviated (APA, 2013).

Interpersonal and environmental theories view depression as the result of a breakdown in communication with family and friends and problems with work, school, and carrying out general activities. Individual, group, and family therapies are used in this context (APA, 2013).

Biological theories

Research indicates that depression may result from variations in levels of the biogenic amines. This theory relates to the catecholamines, dopamine, norepinephrine, and serotonin, and their functioning at receptor sites on brain cells and nerves. There is increasing evidence that supports a chemical connection with depression, although researchers do not yet understand specific pathways that are altered in individuals with depression (Halter, 2018).

Genetic factors also play a role in mood disorders. The prevalence of depressive and bipolar mood disorders is higher among blood relatives than among the general population (Mayo Clinic, 2018a). There is some evidence of a stronger maternal genetic link to depression It has also been shown that the closer the genetic relationship, the greater the likelihood of the diagnosis.

Most recently, a link has been found between inflammation and depression. Patients with depression show slightly elevated C-reactive protein levels in their blood, indicating low-grade inflammation (Osimo et al., 2019). Also, people with chronic inflammatory illnesses seem to have a higher incidence of depression than patients with other chronic illness.

Ongoing scientific research is being conducted in the field of mental illness. Although no definitive cause of depression has been found, more is known about its biological markers, and treatments are being used successfully. Many patients benefit from antidepressant medications, indirectly pointing toward a biological cause. Certainly, more research is needed to pinpoint which medication is best for a particular patient. Right now, to a large extent, healthcare professionals rely on trial and error to discover the most beneficial medication.

RISK FACTORS

Risk factors for depression and bipolar disorders include some physical illnesses that can have a cause-and-effect relationship with depression. Having a chronic illness such as heart disease, stroke, or Alzheimer's disease puts patients at higher risk of developing depression. In these cases, it is necessary to first treat the underlying cause, if possible, to address the depression or other mood disorder (Halter, 2018; National Institute of Mental Health, 2016).

Illnesses

There is increasing evidence that depression is associated with changes in immune functioning. Many inflammatory chronic diseases are associated with high levels of cytokines leading to alterations in immune functioning. These messenger proteins trigger and promote inflammation. Patients with depression have been found to have high levels of cytokines and other inflammation markers. Cytokines and other inflammatory markers provide a link between depression and immune function (Liu et al., 2020). It makes sense that people with inflammatory chronic diseases also have a higher prevalence of depression compared with those who have other chronic diseases.

The prevalence of depression is generally higher in persons who have concomitant medical problems (CDC, 2019, 2016b; Deschênes et al., 2015; Halter, 2018; Kyoung et al., 2015). Table 4 lists some of the medical conditions associated with a higher prevalence of depression.

Table 4. Medical Conditions Associated with Depression

Neurologic Disorders	• Neoplasms • Stroke • Multiple sclerosis • Infection • Trauma • Migraine • Parkinson's disease • Epilepsy • Alzheimer's disease
Endocrine Disorders	• Adrenal disorders • Thyroid disorders • Menses-related disorders • Postpartum disorders
Infectious and Inflammatory Disorders	• Chronic fatigue syndrome • Pneumonia • AIDS • Tuberculosis • Rheumatoid arthritis
Other Medical Disorders	• Vitamin deficiency • Anemia • Cancer (especially pancreatic cancer) • Cardiopulmonary disease • Chronic pain • End-stage renal disease
Non-Mood-Related Psychiatric Disorders That Often Coexist with a Diagnosis of Depression	• Obsessive-compulsive disorder • Panic disorder • Substance-related disorders • Personality disorders • Eating disorders

Based on Centers for Disease Control and Prevention. (2019)/ Depression Statistics. https://www.cdc.gov/nchs/fastats/depression.htm ; Centers for Disease Control and Prevention. (2016a). Children's mental health. Anxiety and depression. https://www.cdc.gov/childrensmentalhealth/depression; Deschênes, S. S., Burns, R. J., & Schmitz, N. (2015). Associations between depression, chronic physical health conditions, and disability in a community sample: A focus on the persistence of depression. Journal of Affective Disorders, 179, 6-13. http://dx.doi.org/; Kyoung, K. W., Dayeon, S., & Won O. S. (2015). Depression and its comorbid conditions more serious in women than in men in the United States. Journal of Women's Health, 24, 978-985. 10.1089/jwh.2014.4919.

Medications

Long-term use of certain medications may cause symptoms of mania or depression in some people. Depression or mania is an idiosyncratic side effect of many medications, including the following (Halter, 2018: National Institute of Mental Health, 2016):
Antidepressants (may precipitate mania)

- Sedatives, tranquilizers, barbiturates, and central nervous system depressants
- Steroids (e.g., glucocorticoids, anabolic steroids)
- Cardiac medications (e.g., antihypertensives and blood thinners)
- Hormones (e.g., oral contraceptives, thyroid medications)

Stress

Stressful life events are difficult for some people, but the same events may not pose problems for others. When assessing patients, the healthcare professional should be aware of the patients' perceptions of their problems as a means of observing for signs and symptoms of depression. Getting a sense of the importance of a situation to the patient is crucial in determining its possible contribution to a depressive episode. Teaching stress management strategies is part of healthcare.

Grief reaction

Depression can be associated with real and imagined loss, such as anything a person valued or once had (or wanted) but is now absent. This includes losing a spouse, parent, child, other family member, or friend to death or even relocation. Situational grieving associated with events such as job loss, divorce, and financial loss commonly are associated with short-term depression. Clearly, some change in mood is considered normal when a loss is experienced, but when it becomes extreme, the patient's condition can turn into long-term depression categorized as bereavement (American Psychiatric Association, 2013; Halter, 2018).

Trauma

Some forms of disaster or physical trauma, such as an accidental injury or a major illness, can precipitate an episode of depression (Wheeler, 2017). Individuals who are injured in a motor vehicle accident and experience residual effects in the form of pain or loss of function may become depressed for some time. As with grief, some degree of sadness or unhappiness is clearly normal, but assessment for depression is in order if symptoms are prolonged.

Postpartum depression

Approximately one in nine women experience postpartum depression (CDC, 2016c). Many more mothers have "baby blues" during the 10-day postpartum period. Baby blues is transient and does not impair functioning. It should not be confused with postpartum depression or postpartum-onset mood episodes (American Psychiatric Association, 2013). It is caused by hormonal shifts or inner psychological conflicts over becoming a mother for the first time or once again (Halter, 2018; National Institute of Mental Health, 2016). Up to one in seven women experience postpartum depression (American Psychological Association, 2020). About half of these women had symptoms during their pregnancy that became worse after the baby was born. Healthcare professionals should encourage patients to report symptoms of depression early, and they should continue to monitor these patients.

Symptoms of postpartum depression generally occur 3 days after childbirth, usually within the 1st week (although they can also manifest much later), and include sleep disturbances, increased anxiety, fatigue, irritability, or negative or ambivalent emotions toward and about the baby. The severity of signs and symptoms varies (Halter, 2018). Perinatal depression, a more widely encompassing term, refers to depression resulting from issues during the pregnancy period through the first 12 months after the baby's birth. Less often, postpartum depression can lead to full-blown psychosis (Halter, 2018). These patients are profoundly depressed and suicidal, hallucinating, or delusional, and have homicidal thoughts or unreal feelings about the child (e.g., that the child is sick or dead). This is not a common problem; it occurs at an estimated rate of 0.89 to 2.6 in 1,000 births (VanderKruik et al., 2017). Because of the brief time new mothers stay in most maternity units and birthing centers, healthcare professionals working on those units may not see the full extent of these disorders.

New mothers may be irritable, anorectic, easily fatigued yet unable to sleep, and tearful. These episodes are usually self-limiting, lasting only a few days. However, these signs and symptoms occur frequently enough to warrant providing the new mother with bedside education about them while she is in the maternity unit. Healthcare professionals working in the community who may see new mothers in their homes 1 week or more after childbirth should be alert to the signs and symptoms of the "baby blues" and its related psychiatric disorder.

Age

An increase in depression has been noted in persons aged 60 years and older. Among older adults, the prevalence of depression is generally twice as high in women compared with men (National Institute of Mental Health, 2016). There has been an increase in the diagnosis of depression in the past 10 years for individuals who are 12 to 18 years of age (American Psychological Association, 2019).

Some of the other high-risk factors for depression include the following:

- Physical illness
- Recent significant loss (e.g., the death of a family member or friend)
- Events such as job loss and subsequent financial problems
- Unhappiness with one's occupation or having no job at all
- Low economic status
- Lack of social networks and social isolation

DIAGNOSTIC ASSESSMENT

Healthcare professionals and other healthcare team professionals conduct psychosocial assessments of each patient whom they encounter. Patients with depression may present with physical or psychological symptoms in various clinical settings. Through empathetic listening, healthcare professionals may uncover symptoms of depression or depressive disorders in patients.

DSM-5 psychiatric diagnoses

The DSM-5 diagnostic categories for symptoms of depression are listed under the two main categories of depressive and bipolar disorders. The healthcare professional may find one of the following psychiatric diagnoses for depressive disorders among the medical diagnoses in the patient's medical record (American Psychiatric Association, 2013):

- Major depressive disorder
- Persistent depressive disorder*
- Unspecified depressive disorder

The ways major depressive symptoms are demonstrated in patients will differ from person to person. To make a diagnosis of major depression, the healthcare provider must determine that a certain number of the following symptoms have been observed within a short time span. All patients must exhibit either one or both of the following (American Psychiatric Association, 2013):

- Depressed mood: feeling sad, empty, hopeless
- Loss of interest or pleasure in usual activities

The patients must also exhibit at least some of these additional indicators (American Psychiatric Association, 2013):

- Disturbance with eating: significant change in weight, a change in amount of food ingested
- Problems with sleep: difficulty falling or staying asleep, sleeping too much or too little, unable to feel rested after sleep
- Constant pacing and/or handwringing; an inability to stay still
- Slowed responses, extreme feelings of tiredness, avoidance of social interaction, and lack of energy
- Feelings of low self-esteem, unworthiness, unnecessary guilt
- Trouble with thinking, distorted thoughts to the point of delusions or hallucinations; cannot concentrate easily
- Obsessing on thoughts of death and/or suicide
- Decreased or absent sex drive

It is important for nonpsychiatric healthcare professionals to be aware of the significance of depression among general hospital

patients. These patients may complain of a variety of physical complaints, such as gastrointestinal problems (indigestion, constipation, and diarrhea), headache, and backache. Additionally, persistent physical symptoms that do not respond to treatment, such as headaches, gastrointestinal disorders, and chronic pain, may indicate depression.

Similarly, the healthcare professional may find one of the following psychiatric diagnoses for bipolar disorders among the medical diagnoses in the patient's medical record:

- Bipolar I disorder
- Bipolar II disorder
- Cyclothymic disorder*

Bipolar I disorder is a disorder in which the person experiences episodes of mania or hypomania (a less intense form of mania) alternating with periods of severe depression. Bipolar II disorder is a different diagnosis that is made when the patient has never had an episode of mania but has shown hypomanic behaviors accompanied by depressive symptoms (NIMH, 2020). The distinction between one of the bipolar categories and major depression can be difficult if the patient presents with only depressive symptomatology (see Table 5). The severity of signs and symptoms in each episode varies from person to person (Mayo Clinic, 2018c).

Table 5. Comparison of Major Depressive Disorder and Bipolar Disorder

Issue of concern	Major depressive disorder	Bipolar disorder
State of mind	Extremely sad, unhappy.	Periodic mood swings between extremely "up" and agitated to extremely sad.
Thought process	Cannot concentrate easily; difficulty with thinking; recall is problematic.	Easily distracted; cannot focus on one thing; racing thoughts; flight of ideas.
Speech pattern	Lack of interest in communicating.	Pressured speech; quick, clipped sentence fragments.
Sleep habits	Significant alterations in sleep patterns; sleeping a lot more than normal or a lot less.	Does not seem to require much sleep.
Energy level	Evidence of less energy.	Abundance of energy; seemingly in constant motion.
Interest in daily activities	Loss of interest in activities previously enjoyed.	Overinvolvement in numerous activities, even ones that are not healthy.
Weight	Changes in weight, either gain or loss.	Probable weight loss because of excessive activity level.
Level of self-esteem	Much lower self-esteem; feelings of unworthiness, guilt, and/or hopelessness.	Exaggerated sense of self.
Suicidal ideation	Frequent thoughts of death and dying; may not have energy to construct a plan.	Possible thoughts of suicide during depressive episodes.

Kempton, M. M. J., PhD. (2011). Structural Neuroimaging Studies in Major Depressive Disorder: Meta-analysis and Comparison With Bipolar. Jama Network. https://jamanetwork.com/journals/jamapsychiatry/fullarticle/1107416

To be diagnosed with mania, the patient has demonstrated an unusually high energy level along with an elevated mood for a week or more. Specific behaviors may include the following (American Psychiatric Association, 2013):

- Has thoughts of self-importance and eagerness to share this with others
- Experiences a seemingly inexhaustible energy level; does not seem to need sleep
- Is very talkative with an apparent "need to talk"; thoughts race from one topic to another
- Easily distracted
- Plans lots of projects to accomplish
- Engages in many various behaviors that are out of character for the individual

NANDA healthcare diagnoses

NANDA healthcare diagnoses for patients with mood disorders may include one or more of the following (Herdman & Kamitsuru, 2018):

- Anxiety (e.g., mild, moderate, severe, panic)
- Coping (e.g., ineffective, readiness for enhanced, compromised family, defensive)
- Grieving (e.g., anticipatory, dysfunctional)
- Hopelessness
- Noncompliance; nonadherence
- Nutrition, altered; more or less than body requirements
- Post-trauma syndrome or risk
- Role performance, ineffective
- Self-care deficit
- Self-esteem (e.g., chronic low, situational low, risk for low)
- Sleep pattern, disturbed
- Social interaction, impaired
- Social isolation
- Violence, risk for other- or self-directed
- Suicide risk

HEALTHCARE PROFESSIONAL INTERVENTIONS

Patients in a general hospital setting may experience a mood disorder. They may be receiving treatment for the disorder before or during their hospital stay. Assessment of suicide risk in these patients is critical. Healthcare interventions for patients who have mood disorders are quite effective in helping the patients maintain a psychosocial balance while in the hospital and perhaps in helping them take steps for ongoing care.

Healthcare professionals who administer care at the bedside can provide valuable assistance to these patients by using some of the healthcare interventions listed in Table 6.

Table 6. Healthcare Interventions and Rationale for Patients with Mood Disorders	
Healthcare intervention	**Rationale**
Be accepting. The patients may have a negative outlook and low self-esteem.	An attitude of acceptance enhances feelings of self-worth.
Be nonjudgmental, develop a trusting relationship, and be open with the patients.	Trust is basic to a therapeutic relationship.
Assess the patients often. Provide a safe environment.	Depressed patients need short, frequent contacts to assure them that they are supported, safe, and attended to, even when they may feel that they are not worth the healthcare professional's attention.
Screen patients for depression by asking: • "During the past 2 weeks, have you felt down, depressed, or hopeless?" • "During the past 2 weeks, have you felt little interest or pleasure in doing things?"	If the patients respond positively to the two questions, the healthcare professional can inform the physician, and the patients can receive appropriate treatment for depression.
Assess the patients for suicidal ideation and initiate safety checks and procedures as needed.	Patients with depression may have suicidal feelings and thoughts. They may need protection from harm.
Assess the patients for any indications of a thought disorder.	Some patients with depression have accompanying psychotic thoughts.
Assess the patients' ability to perform self-care tasks.	Depression may decrease the patients' ability to continue activities of daily living.
Assess the patients' sleep patterns and determine methods to either reduce or increase sleep, for example, by using relaxation techniques, decreasing stimulation at rest time, and drinking warm milk.	Disturbances in sleep patterns are common in patients with depression or bipolar disorder.
Reduce the environmental stimuli for patients experiencing a hypomanic or manic episode.	Patients are generally quite easily distracted when they are manic.
Provide structure and set limits as guides for patients with mania. Do not allow a patient with manic behavior to get exhausted.	Generally, patients with mania show poor judgment and impulsivity; they may need guidance.
Provide the patients an opportunity to express pent-up emotions or discuss problems (e.g., grieving a loss, internal mood, isolation, dysfunctional thinking).	If patients recognize possible precipitating events, they can take steps to: • reduce the occurrence of the events and • devise strategies that may reduce or eliminate the stressors.
Allow the patients to cry in a supportive environment.	The patients may relieve pent-up feelings by crying.
Help the patients determine appropriate ways of expressing anger.	Patients with a moderate amount of depression are often angry.
Assist the patients with problem solving.	Problem solving reduces stresses and increases the patients' self-esteem.
Encourage patients to make their own choices when they experience feelings of powerlessness.	Patients gain a sense of control and mastery when they make choices.
Encourage depressed patients to increase their interpersonal contacts.	Interpersonal relationships can reduce feelings of social isolation.
Administer prescribed medications: • Assess the effectiveness of the medication. • Monitor the patient for potential side effects.	Medications are frequently an effective treatment for depression or bipolar disorder. They need to be administered as prescribed and may take a while to work.
Teach the patients about the self-administration of prescribed medications.	Although beneficial for many patients, medications are quite potent and must be monitored carefully.
If the patients have experienced a loss, describe the stages of grieving, and teach the patients about them.	Knowledge of the process of normal grieving helps patients accept their own feelings.
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TREATMENT OPTIONS

Different types of treatment are used for patients with mood disorders, and consideration is given to the patients' history as well as the severity of signs and symptoms. In general, a combination of some form of psychotherapy and psychotropic medication is the preferred treatment.

Psychotherapies

Psychotherapy, a goal-oriented approach aimed at helping patients deal with a specific issue, is used in both inpatient and outpatient settings on short- and long-term bases. Patients may be treated individually, within groups, or with family members.

Scientific evidence indicates that several forms of short-term psychotherapy (cognitive, interpersonal, and behavioral) are effective in treating most patients with mild or moderate depression. Psychotherapy can also be helpful to patients with bipolar disorder who are no longer experiencing acute mania. Group work, which involves education and support from professionals and from others with the same condition, has been shown to improve patient outcomes (Hubbard et al.).

Psychotherapy is based on a variety of theories, such as systems theory, communications theory, and interpersonal theory (American Healthcare professionals Association et al., 2014). Psychotherapy can help individuals understand some of the dynamics of their illness and promotes adherence to psychopharmacologic therapy.

Psychopharmacologic therapy

Beginning in the 1960s, the use of tricyclic antidepressants and monoamine oxidase inhibitors (MAOIs), in combination with psychotherapy, constituted the principal mode of treatment and remained so for many years. As research continues, newer forms of medication are introduced, providing more successful treatment and more options for individuals who experience depression.

Depression

Currently, selective serotonin reuptake inhibitors are the first-line treatment for depression because they work faster and have fewer serious side effects than the older drugs. These selective serotonin reuptake inhibitors include:

- fluoxetine (Prozac, Sarafem, Symbyax)
- paroxetine (Paxil, Paxil CR, Pexeva)
- sertraline (Zoloft)
- escitalopram (Lexapro)
- citalopram (Celexa)
- vilazodone (Viibryd)

Generally, tricyclic antidepressants take 2 or 3 weeks to produce initial therapeutic results. They are sometimes prescribed to treat moderate to severe depression. They include:

- amitriptyline
- desipramine (Norpramin)
- nortriptyline (Pamelor)
- protriptyline (Vivactil)
- trimipramine (Surmontil)
- maprotiline

Both tricyclic antidepressants and MAOIs, including phenelzine (Nardil) and tranylcypromine (Parnate), prevent the breakdown of neurotransmitters. Neurotransmitters such as serotonin and norepinephrine keep an individual calm and happy. These drugs allow the neurotransmitters to stay near the nerve cells longer by preventing their breakdown and reabsorption . A more recently introduced medication in the MAOI drug group, selegiline (Emsam), is administered through a transdermal patch and seems to create fewer unpleasant side effects than the earlier MAOIs. MAOIs are primarily used only when other options have failed because they have potentially serious side effects resulting from interactions with certain other medications and foods.

Often the patient's condition improves after the first few weeks of taking antidepressant medications; however, these medications must be taken regularly for 3 to 4 weeks (sometimes as many as 8 weeks) before the full therapeutic effect occurs (Townsend & Morgan, 2017).

Bipolar Disorder

People with bipolar disorder are generally treated with lithium carbonate (Lithobid), valproic acid (Depakene), divalproex (Depakote; Depakote ER), carbamazepine (Epitol, Tegretol, Carbatrol), or lamotrigine (Lamictal, Lamictal XR). These medications are effective in the management and stabilization of the illness 50% to 80% of the time. Patients who are taking lithium carbonate must have their serum drug levels monitored closely. The medication must be taken continuously; its effectiveness is contingent on maintaining a narrow therapeutic blood level. In addition, because lithium is excreted via the renal system, serum creatinine and blood urea nitrogen should be monitored as well. The antiepileptic medications carbamazepine and divalproex additionally require monitoring of hepatic function and platelets periodically because of the increased risk of hepatotoxicity, blood dyscrasias, and pancreatitis.

Electroconvulsive Therapy

Electroconvulsive therapy (ECT) can be an effective treatment for the alleviation of depression. Generally, it is used only after a trial of antidepressants has failed or for patients at extremely high risk for suicide.

During the procedure, the patient is anesthetized, and a seizure is induced. Six to 10 treatments are given in a series over 2 to 3 weeks. ECT is indicated primarily for major depressive disorder. Today patients are given lower doses of current and are sedated, so ECT is much safer than in the past.

Although the short-term memory loss associated with this type of therapy is well known, more profound and longer lasting adverse effects are rare. ECT is used for people whose depression does not respond to medications, for those at high risk of suicide, and for severely depressed older adults who cannot take medications because of heart disease (Halter, 2018).

In some healthcare settings, healthcare professionals may assist with the administration of ECT on an inpatient or outpatient basis and provide healthcare to the patient who has received ECT. On a home visit, at an outpatient clinic, or during an office visit, the healthcare professional needs to monitor the effects and side effects of treatment for patients who have had ECT.

Case study 6

Jackson is a 19-year-old college student who recently withdrew from all courses after a manic episode that resulted in a police investigation. He reports binge alcohol drinking, impulsivity, and several long periods of deep depression. His diagnosis of bipolar disorder is devastating to him and his family.

Self-Assessment Quiz Question #7

Teaching for this family should include all except:

a. The side effects of antipsychotic drugs.
b. The importance of staying on the medications, even after the symptoms are reduced.
c. The importance of avoiding all over-the-counter medications.
d. The importance of a gluten-free diet.

Self-Assessment Quiz Question #8

The healthcare professional should also teach the family that:

a. Jackson is not behaving appropriately.
b. If the treatment plan is too cumbersome, Jackson can stop.
c. There are community and online resources because group support has been found to be effective.
d. Jackson is old enough to manage his health independently.

Evidence-based practice! Diet matters in all things. As depression is thought to be part of an inflammatory process, eating an anti-inflammatory diet is worth trying (Tolkien et al., 2019). The Mediterranean diet includes foods high in antioxidants. Whole foods, fresh raw or slightly cooked vegetables, foods rich in omega-3 fatty acids, spices such as turmeric, and some teas are examples of these foods.

Additionally, there is strong evidence that specific vitamins and minerals are effective as part of an approach to reduce inflammation and depression and increase overall health. One study (Yeum et al., 2019) suggested supplementing with vitamins D, B12, B9, and vitamin C, as well as zinc, selenium, and omega-3 fatty acids.

Healthcare Professional Consideration: Self-care of the healthcare professional is an important part of treating patients with mood disorders. Patients with mania can be quite fun, though their behaviors and the consequences of their actions often go too far. Patients who are severely depressed are difficult to work with, and after the interaction the healthcare professional feels tired, slow, and perhaps irritated or depressed. Becoming more self-aware is a learned skill. Studies show that a self-aware healthcare professional is essential for developing the therapeutic healthcare professional-patient relationship that is needed (Rasheed et al., 2019). To become more self-aware, the healthcare professional can think back and reflect on the situation; talk out the experience with a trusted mentor or colleague; and focus on the positives and learn from the negatives of the experience.

HOLISTIC CONSIDERATIONS

Transcranial magnetic stimulation is a new noninvasive treatment for major depressive disorders that is the choice for patients who have not responded to the usual medications (Dubin et al., 2016). An alternative to medication, this treatment is considered safe, well tolerated, and effective (Mayo Clinic, 2018d). Magnetic fields are created around the brain with an electromagnetic coil placed against the forehead. There is no pain or seizures with this procedure though the patient may experience slight discomfort. Parts of the brain that are influenced by depression are activated, and the depressive mood lifts for the patient (Janicak & Dokucu, 2015). The procedure takes about 40 minutes and is often repeated every few weeks until depression symptoms are reduced.

Transcranial magnetic stimulation should not be confused with ECT, which involves anesthesia and the induction of a seizure with electricity and results in changes in brain functioning and chemistry. ECT is still used across the United States for severe depression (NIMH, 2019).

Case study 7

Mary Lincoln is a 47-year-old female patient who was admitted to a surgical unit of a general hospital for removal of an ovarian cyst. The procedure went well, and Mary is doing fine medically. She appears to be free from pain and is recovering well.

The evening healthcare professional who is taking care of Mary notes that she seems depressed. The healthcare professional observes that Mary has a sad mood and appears helpless or extremely lethargic when performing everyday tasks such as opening her juice or using the washcloth to clean her face.

On Mary's recorded psychosocial assessment, the healthcare professional learns that Mary and her husband divorced last year. Her second child, a daughter, has moved out of state within the past 2 months to attend college, and her oldest child, a son, is married and living 1,000 miles away.

When the healthcare professional inquiries about Mary's mood, Mary admits that she has felt somewhat sad for at least a month, has had frequent crying spells, has had a poor appetite, and has been more tired than usual. She claims that she falls asleep easily at about 11:00 p.m. each night at home but finds herself wide awake at 2:00 a.m., unable to return to sleep and feeling quite dreadful.

Mary says she knows that she should be feeling happy and excited; her surgery was successful, and she recently learned that her son and his wife are going to have a baby. She verbalizes that she cannot understand what is wrong with her because she is really looking forward to becoming a grandmother. Mary does confide that she would have liked to share the grandparenting experience with her ex-husband and wishes that her son lived closer to her.

Self-Assessment Quiz Question #9

The healthcare professional should be aware that depression is:

a. Usually a call for attention.
b. Underdiagnosed.
c. Related to an unhappy event.
d. Triggered by other depressed people.

Self-Assessment Quiz Question #10

This patient will likely be diagnosed with

a. Bipolar disorder.
b. Anxiety.
c. Depression and anxiety.
d. Depression.

Conclusion

This course has covered the levels of anxiety and depressive disorders, physiological reactions to them, specific medical and healthcare diagnoses that are appropriate, and possible healthcare options. Because healthcare professionals spend so much time with patients, they are in a strategically important position for assessing the patients' mood. Patients who have a mood disorder are seen regularly in the general hospital setting. Healthcare professionals can take the necessary steps to ensure that patients receive appropriate treatment for psychiatric and mental health conditions while in the hospital and after discharge. Being able to successfully intervene and curb a patient's escalating anxiety or help manage a patient's depressive disorder is a necessary skill for all healthcare professionals, in all specialties.

Glossary of terms

Anxiety: An unpleasant feeling of dread and apprehension. It may be caused by an unconscious conflict between an underlying drive and the reality of the environment, or it may be precipitated by a physical illness or a stressful situation. Patients who are anxious are often unaware of the specific cause of their feelings (Mayo Clinic, 2020).

Fear: A distressing emotion aroused by impending danger, evil, pain, and so on, whether the threat is real or imagined; the feeling or condition of being afraid. Fear is an unpleasant feeling caused by the realization and recognition that some event, occurrence, or other detectable source in the environment may bring harm.

Stress: The natural occurrence of wear and tear on the body as it responds and adapts to life's events. Classically described by Selye (1976), stress is generally recognized as a complex phenomenon. Accordingly, the understanding of stress must emphasize the relationship between the person and environment, the situation and the person's physiological state, and the current event and the person's history of stress and coping. To some extent, stress is a very individual experience: Something that is stressful for one person might be only mildly irritating to another. Likewise, responses to stress vary from one individual to another.

Coping mechanisms: Those behaviors that serve to reduce an individual's anxiety. They may be helpful or not, adaptive, or maladaptive. Healthcare professionals and other healthcare providers can teach patients to find healthy coping strategies (Halter, 2018; Townsend & Morgan, 2017; Riley, 2020).

Crisis: An internal disturbance that results from a stressful event or hazardous situation or a perceived threat to oneself. During times of crisis, the patient's usual coping mechanisms may become ineffective. At this point, a patient is more receptive to therapeutic influence and can often learn new coping mechanisms. Fortunately, a crisis is a time-limited event (Halter, 2018; Townsend & Morgan, 2017).

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Self-Assessment Answers and Rationales

1. The correct answer is A.
Rationale: This acknowledges Judy's concern about the interview and encourages her to talk more about it.

2. The correct answer is A.
Rationale: Judy is experiencing mild anxiety because of her upcoming interview. It is important to her, and she is excited about the possibilities of a new job that she thinks will be a great fit for her skills. She is alert and aware of her surroundings. She seems able to articulate her situation and think logically about her interview.

3. The correct answer is D.
Rationale: There is probably no anxiety attached to the in-service testing because there is nothing required of the healthcare professionals other than to go and sit in the room and fill out the testing form.

4. The correct answer is A.
Rationale: Mild anxiety creates the best learning environment. If any of the other levels of anxiety are present, the person cannot absorb new information as effectively.

5. The correct answer is C.
Rationale: Roberto is experiencing severe anxiety. He is focused only on his pain and has become verbally combative.

6. The correct answer is C.
Rationale: Being self-aware of one's feelings and behaviors is part of self-care. The American Holistic Healthcare Professionals Association recognizes self-care as essential to effective healthcare practice.

7. The correct answer is D.
Rationale: Antipsychotic medications are generally not part of medication protocols for patients with bipolar disorders. Education for this family should be centered on recognizing early warnings for mania and possible triggers and the importance of continuing to take the medication. In a manic phase, patients believe they feel great and often discontinue medications. The family needs to understand that this is a biological disorder, as they may believe this is only a behavioral issue. Gluten-free diet is unrelated.

8. The correct answer is C.
Rationale: The healthcare professional should consider referring the family to a support group and other resources in the community and online. The family does not need to be told how Jackson's behavior is. Stopping treatment is not recommended without some sort of follow-up. Jackson may need help even though he is considered an adult at 19 and the family is an excellent resource.

9. The correct answer is B.
Rationale: Many people are not yet diagnosed with depression but have all the symptoms. The Beck Depression Inventory is a quick checklist that anyone can use to check for symptoms, and it is often part of intake for hospital admissions.

10. The correct answer is D.
Rationale: More than likely, Mary is experiencing depression. She reports typical signs and symptoms (i.e., sad mood, feeling helpless and lethargic), and her situation, with multiple experiences of loss, would be one that might lead to depression. Asking about previous episodes of depression or similar symptoms and whether she has a history of depression, as well as her response to the symptoms and treatment, if any, would be helpful in creating a plan of care for Mary.

HOW TO COMPLETE THIS BOOK FOR CREDIT

Please read these instructions before proceeding.

IF YOU'RE COMPLETING ALL COURSES IN THIS BOOK:

- Go to **EliteLearning.com/Book** and enter code **ANCCAR1523B** in the book code box, then click **GO**.
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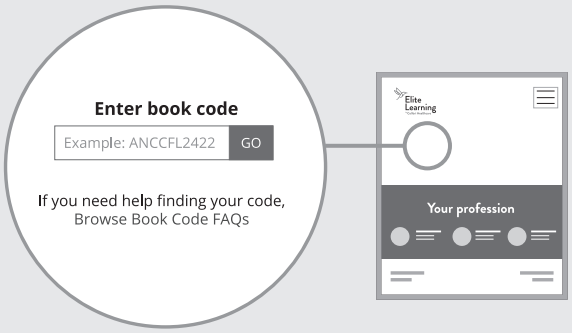

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All 15 hours in this correspondence book	**ANCCAR1523B**
Basic Psychiatric Concepts	ANCCAR06PC
Cultural Humility for Healthcare Professionals	ANCCAR03CH
Documentation in the Electronic Age for Nurses	ANCCAR03EA
Management of Anxiety and Depression for Healthcare Professionals	ANCCAR03AD

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- All completions will be processed within 2 business days of receipt and certificates e-mailed to the address provided.
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Using the spaces provided below, please PRINT the information below in CAPITAL LETTERS. All information below must be filled in completely. Upon completion, please return this sheet along with payment and mail to the address above. If paying by check or money order, please make payable to Elite for $34.95. For faster service, we offer this test online with instant grading and certificate issuance. Please visit **EliteLearning.com/Book** to complete your test online.

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Important Note:
The box below must be checked for verification sheet to be processed.

☐ By checking this box and signing below, I hereby affirm that I have completed this educational activity, including the self-assessment. If faxing or mailing be sure to also fill out and include course evaluation.

_____

Signature

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ANCCAR1523B

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1. ANCCAR06PC 2. ANCCAR03CH 3. ANCCAR03EA 4. ANCCAR03AD

NURSING - COURSE EVALUATION (ANCCAR1523B - Required)

To receive continuing education credits for this program, this mandatory evaluation form must be completed.

Licensee Name: _____ **License #**_____

Your honest feedback is vital for the planning, evaluation, and design of future educational programs.

SECTION I: Demographics: Your current license type and education level: ❍LPN/LVN ❍RN - Associate degree ❍RN - Bachelor's degree ❍RN - Master's degree ❍APRN - Master's degree ❍Doctorate / DNP / Other Doctorate ❍Other (specify)_____

How long have your been a nurse: ❍Less than 5 years ❍6 to 10 years ❍11 to 15 years ❍16 to 20 years ❍Over 20 years ❍Not a nurse

SECTION II: Course Evaluation
Please complete the following for each course you have completed. Mark the circle that best matches your evaluation of the question.

1. After completing this course, I am able to meet each of the Learning Outcomes.	7. The course demonstrated the author's knowledge of the subject.
2. The course content was unbiased and balanced.	8. I intend to apply the knowledge from this course to my practice.
3. The course was relevant to my practice.	9. What I have learned from this course will have an impact on my knowledge.
4. I would recommend this course to my peers.	10. What I have learned from this course will have an impact on patient outcome.
5. What I have learned from this course will have an impact on my practice.	11. The overall rating for this course.
6. The course was well-organized and clear.	

	Basic Psychiatric Concepts 6 Contact Hours					Cultural Humility for Healthcare Professionals 3 Contact Hours				
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
2	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
3	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
4	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
5	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
6	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
7	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
8	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
9	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
10	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
	Excellent	Good	Average	Below Average	Poor	Excellent	Good	Average	Below Average	Poor
11	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
12	How many total hours did it take you to complete this course? Please indicate the number of hours: _____									
13	Please provide any additional feedback on this course: _____									

SECTION III: General

Fill in the circle below numbers **0=Not likely at all, 5=Neutral and 10=Extremely likely**

How likely is it that you would recommend Elite to a friend or colleague?..... 0 1 2 3 4 5 6 7 8 9 10

If your response is less than a 10, what about the course could we change to score a 10? _____

_____

List other topics that you would like to see provided: _____

❑ I agree to allow Elite to use my comments. If you agree, please provide your name and title as you would like to see them to appear.

_____

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6. The course was well-organized and clear.	

	Documentation in the Electronic Age for Nurses 3 Contact Hours					Management of Anxiety and Depression for Healthcare Professionals 3 Contact Hours				
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
2	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
3	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
4	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
5	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
6	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
7	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
8	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
9	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
10	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
	Excellent	Good	Average	Below Average	Poor	Excellent	Good	Average	Below Average	Poor
11	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
12	How many total hours did it take you to complete this course? Please indicate the number of hours: _____									
13	Please provide any additional feedback on this course: _____									

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_____

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_____