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A Concise Textbook of

Psychiatric Mental Health NURSING

(As per INC Syllabus)



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Foreword
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JAYPEE

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3 Assessment of Mental Health Status

The evaluation of psychiatric clients is a multifaceted endeavor, most effectively performed by interdisciplinary team of mental health professionals. The ability to assess clients is one of the most important skills of a psychiatric nurse.

PSYCHIATRIC NURSING INTERVIEW

An interview is a conversation with a deliberate purpose that ideally is accepted by the participants. In no other branch of medicine is the history-taking interview as important as in psychiatry.

The purpose of the psychiatric nursing interview is to gather information which is necessary to understand and treat the clients.

The content and process of the interview vary according to the state of the participants and the context in which the interview takes place. The members of multidisciplinary team share the responsibility for data collection.

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

Biopsychosocial History

Psychiatric history helps to gather information about a client and helps the examiner to make diagnosis about his problem. Psychiatry has no external validating criteria, no laboratory test to confirm the diagnosis. Psychiatric history collection is having an important role in making the diagnosis of client's problem, which depends on the skills and knowledge of the examiner.

Definition

'The psychiatric history is record of patient's life and it allows the mental health team members to understand who that patient is, where the patient has come from and where patient is likely to go in future.'

Purpose

- To allow the clients and family members to express their feelings freely in their own words.
- Psychiatric history collection helps to identify the symptoms, how these symptoms are developed and the effect of these symptoms on person's life.

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- Helps to identify the causes of illness.
- Helps to make easy diagnosis and management of the illness.
- To identify psychiatric emergencies.
- To provide insight into the nature of relationship with closest people.

Box 3.1: History collection overview

- Identification of data of the client
- Informant
- Presenting chief complaints
- History of present illness
- Treatment history
- Past psychiatric and medical history
- Family history
- Personal history

Identification and Demographical Details

These details includes client's name, age, sex, religion, address, socio-economic status, inpatient number, education, occupation, marital status, details of informant and relation to the patient.

Presenting Chief Complaints

Here, symptoms are written in chronological order with its duration. These details are collected from patient and if he deny then collect from relatives. Write down the details in patient's own words without changing its meaning.

Enquire about the onset of illness also; it may be acute or insidious. The progress may be steady and progressive, diminishing or reappearing periodically.

History of Present Illness

In this record, all the details of symptoms from its starting. Patient's history can be supplemented with data available from other sources. Record the data.

Treatment History

Record the details of treatment like psychopharmacological drugs, electroconvulsive therapy (ECT), psychological therapies, etc.

Past Psychiatric and Medical History

Collect the details about the past psychiatric history. If patient had any previous episode of psychiatric illness, its nature, duration, the treatment received and outcome should be recorded.

If the patient has any medical illnesses it should be included in the history. The duration of illness, its treatment, history of any accidents, hospitalizations, etc. should be recorded.

Family History

Collect the details of family like type and size of family. The presence of any psychiatric illness on the paternal or maternal side; note specifically the history of suicide, mental

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retardation, epilepsy or any other genetically transmitted disorders. Construct the family composition and genogram (family tree) with the collected details of the family members.

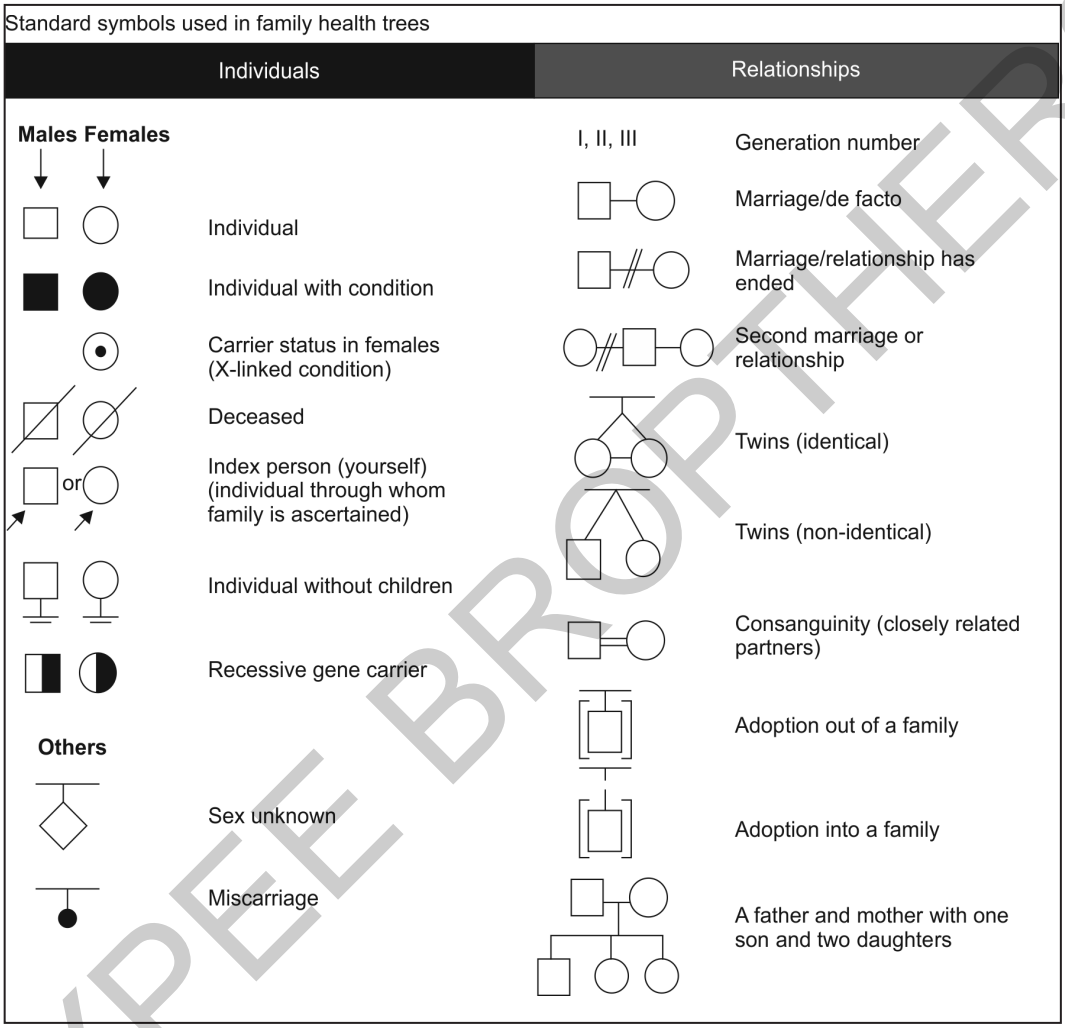

Fig. 3.1: Common pedigree symbols

Personal History

Personal history includes the developmental, educational, occupational as well as the sexual history of the patient. *Developmental history* includes the details of pregnancy and delivery, developmental milestones, occurrence of any significant events like separation from parents, migration, etc.

The *educational history* relates to the details of levels of performance in school, relation with peers and teachers, academic achievements, etc. and in *occupational history,* collects the details of type of work, job satisfaction, frequent change in job, etc.

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In *sexual history* collects the details about sexual development, attitude towards sexuality. In *marital history,* enquire about married life, relation with spouse and children.

Collect the details of *premorbid personality*; it is the personality of the individual prior to the illness. Ask about the social relationship, interests and hobbies, mood changes, habits, character, fantasies, ambition, religious view, etc. ***(See Appendix 1)***

Mental Status Examination (MSE)

Mental status examination (MSE) is a standardized format in which the clinician records the psychiatric signs and presents at the time of interview.

The MSE of psychiatric patients is analogous to the physical examination in physical medicine. It provides a format for the systematic observation and recording of information about a person's thinking, emotions, and behavior. These data combined with information from the history are the basis for formulating a differential diagnosis.

Box 3.2: Aspects of mental status examination (MSE)

Physical
- General appearance
- Motor activity and behavior

Emotional
- Mood and Affect

Cognitive
- Speech
- Attention, concentration
- Memory
- Thought
- Intelligence
- Abstract thinking
- Perception
- Insight
- Orientation
- Judgment.

General Appearance and Behavior

This is the general description of patient's behavior. This shows his sensorium, alertness, cooperativeness, mannerisms, involuntary movements, etc.

Speech

The manner of speaking and its defects are recorded under speech. Assess the rate, quantity and flow of speech. Check for the initiation. Record a sample of speech for later analysis.

Thought

Inference about the thought and its disorders are made from the speech sample or the writing sample of the patient. Disorders of form, content and possession may be present. Check for delusions, obsessive ruminations and thought alienation.

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Mood and Affect

The patient should asked about his affective state. Check that his mood is appropriate or not. Is the emotional expression is blunt and colorless? Does the patient has any suicidal ideas?

Perception

Observe for any type of perceptual abnormalities like illusions and hallucinations. If hallucination is present, find out which type of hallucination and patients reaction.

Attention and Concentration

Assess the patient's ability to attend and maintain attention during the allocated task.

How is his concentration? Can his attention be easily aroused and sustained? Is he distractible?

Some simple tests can be administered. Ask the client to name the days of week or names of months forwards and backwards. He may be asked to subtract 7 or 3 from 100 (100, 93, 86, 79, etc) up to 1.

Orientation

Check whether the patient is oriented to time, place and persons. A defect in orientation reflects cognitive disorders. Orientation involves the ability to tell correctly the time of day, date, week, month, where he is and how he came and correct identification of people around him.

Memory

In which the immediate, recent and remote memory should be tested. *Immediate memory* can be tested by asking to repeat the digits or letters presented to him. *Recent memory* can be tested by asking some events of past 24 hours. *Remote memory* can be tested by asking the details of his past life, schooling, etc.

Intelligence

Patient's educational level, vocabulary, abstract thinking and reasoning give an idea about his intellectual capacity.

Insight and Judgment

Awareness of illness and readiness for taking treatment reflects the insight of the patient. Judgment refers the patient's plans for his future. ***(See Appendix 2)***

INVESTIGATIONS

After taking psychiatric interview and mental status examination, it is important for the mental health care professionals to know about some of the medical investigations and neuro imaging techniques. These investigations are carried out based on the diagnostic and etiological possibilities.

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These tests may perform as a part of routine examination, to identify the drug concentrations in blood (e.g. lithium), before starting the administration of some psychiatric drugs, in case of side effects of drug and prior to ECT. Some of the common investigations are given in the box below.

Box 3.3: Common investigations performed

Name of tests	Type of tests
Complete hemogram	Total and differential count, ESR, hemoglobin
Renal function tests (RFTs)	Blood urea, serum creatinine
Urinalysis	Routine examination
Liver function tests (LFTs)	SGOT, SGPT, serum alkaline, phosphatse, bilirubin level
Thyroid function tests (TFTs)	T_3,T_4,TSH
Blood sugar	Fasting and post prandial blood sugar
Serum electrolytes	Level of sodium, potassium, calcium and chlorides
Serum lithium	Patient with the treatment of lithium salts
X-ray skull, ECG	Prior to ECT.

Abbreviations: ECG—Electrocardiagram; ESR–Erythrocyte sedimentation rate; SGOT—Serum glutamic oxaloacetic transaminase; SGPT—Serum glutamic pyruvic transaminase; T3—Triiodothronine; T4—Thyroxine; TSH—Thyroid stimulating harmone; ECT—Electroconvulsive therapy

NEUROIMAGING TECHNIQUES

Brain function can be identified by using various imaging techniques which helps in determining the normal and abnormal activities of brain and also helps in identifying various anatomical differences in various psychiatric disorders. Various neuroimaging techniques are given in the box.

Box 3.4: Common neuroimaging techniques used

Name of test	Procedure	Indications
Electroencephalo graphy (EEG)	Graphical representation of brain waves with the help of electrodes	Dementia, seizures, other degenerative disorders
Computed tomography (CT) scan	Study of brain structures by the radiographic, three dimensional images obtained through computer	Structural changes in schizophrenia, bipolar disorders, dementia, delirium, seizures
Magnetic resonance image (MRI)	Brain activity and functions are notified by placing head in the magnetic field which induces brain to emit radiowaves	Structural and functional changes in brain, any ischemic changes (transient ischemic attack)
Brain electrical activity mapping (BEAM)	A computed tomographic technique is used to display the EEG recording of the brain electrical activity by using flash light, or sudden sound	To assess the brain activity and function
Positron emission tomography (PET)	A radioactive substance is injected in the brain which shows bright spots on the scan taken up by different tissues	To study the brain structure and physiology like neurotransmitter activity

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Name of test	Procedure	Indications
Single positron emission computed tomography (SPECT)	It is similar to PET, more stable substances than PET are used to visualize the blood flow pattern in the brain	To detect cerebrovascular accident (CVA) and brain tumor.

Neurological Examination

The neuro assessment is a key component in the care of the neurological patient. Nurses working in psychiatric department need to have knowledge and skill in performing a neurological assessment.

Purpose

- To rule out nervous system dysfunction
- To establish a baseline for mental status
- To monitor the progress of disease
- To determine the type of therapy.

Components of Neurological Assessment

Following are the components of neurological examination:

- Patient history
- Level of consciousness
- Mental status examination
- Cranial nerve testing
- Motor function
- Sensory function
- Cerebellar function.

Patient History

A thorough history is the most important part of neurological examination and must be performed before any other procedures unless impossible. History can be collected from patient or from a reliable informant.

Level of Consciousness

Consciousness is the most sensitive indicator of neurological change. Consciousness can be defined as a state of general awareness of oneself and the environment. Consciousness is difficult to measure directly but it is estimated by observing how patients respond to certain stimuli.

Assessing the level of consciousness is an important part of neurological examination.

There are various terms used to describe altered level of consciousness like alert, lethargy, stuporous, semicomatose, comatose, etc.

Glasgow Coma Scale (GCS) is one of the common measure to assess the level of consciousness which quantifies the level of consciousness from 3 to 15, a score of 15 indicates best level and a score of 3 indicates the least level of consciousness.

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Box 3.5: Glasgow Coma Scale (GCS)

Eye opening	Verbal response	Motor response	Score
		Obeys commands	**6**
	Oriented	Localizes pain	**5**
Spontaneous	Confused	Flexion withdrawal	**4**
To speech	Inappropriate words	Abnormal flexion	**3**
To pain	Incomprehensible sounds	Extension	**2**
None	None	None	**1**
Total best score of 15.			

Mental Status Examination

The client's higher cognitive functioning can be assessed by examining orientation, attention, concentration, memory, judgment and abstract thinking. The details of MSE has been already discussed in this chapter earlier.

Cranial Nerve Examination

The cranial nerves arise directly from the central nervous system (CNS). Most often, a neurological problem is detected through the assessment of these nerves. There are 12 pairs of cranial nerves, and the cranial nerve assessment tests are summarized in the box below.

Box 3.6: Assessment of cranial nerve functioning

Nerve	Function	Assessment
I. Olfactory	Smell	Instruct the patient to close the eyes, occlude one nostril and ask to identify the odor. Repeat for the opposite nostril. (Familiar substances such as coffee, lemon, peppermint, etc. are used).
II. Optic	Vision	Gross assessment of visual field is carried out in the following manner. Instruct the patient to close one eye. The examiner closes his/her opposite eye then positions her fingers off to the side at eye level at the same distance between the patient and herself. The examiner's moving finger is then brought into the main boundaries of the visual field. The patient states when the moving finger is seen. This exercise is repeated with the opposite eye.
		Fundoscopic examination: The retina, retinal arteries, veins of optic nerve are visualized through an ophthalmoscope. Increased intracranial pressure is indicated when the vein is congested of the optic nerve head is swollen .

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Nerve	Function	Assessment
III. Oculomotor	Eyelid elevation, EOM (extraocular movements), pupil size and reactivity	Instruct the patient to fix his eyes on an object. Shine the beam of torch directly into each pupil. Note the size, shape of reaction of the pupils to the light stimulus. The pupil size should be noted before and after the light is directed into the eye.
IV. Trochlear	EOM—turns eye downward and laterally	To assess ocular movements ask the patient to follow an object moved systematically in various directions up, down to the right, and to the left. Note for diplopia, limited eye movements of the presence or absence of nystagmus.
V. Trigeminal	Facial sensation and jaw movements	The patient is asked to close his eyes while a wisp of cotton is passed gently over various parts of the face. The patient is asked to identify where the cotton is applied each time. The motor component is evaluated by telling the patient to open his / her mouth wide of hold tightly. The examiner then attempts to close the patient's mouth using hands.
VI. Abducens	EOM—turns eye laterally	Same as like occulomotor and trigeminal nerve test.
VII. Facial	Facial expression, taste, corneal reflex, eyelid and lip closure	The patient is asked to identify the taste of sugar after which a sip of water is given. The same procedure is followed using a salty, sour and bitter substance. Motor function is tested by having the patient wrinkle forehead, smile, showing teeth and wrinkling eyes. Asymmetrical movement or facial drooping is to be noted.
VIII. Vestibulocochlear	Hearing, equilibrium	Tested by using a ticking watch one to two inches away from the patient's ear or using a tuning fork, hearing in both the lift and right ears should be compared. The Weber test and Rinne test may be done to differentiate between conduction deafness of nerve deafness.
IX. Glosso-pharyngeal	Swallowing, gag reflex, taste	• Instruct the patient to open mouth and say 'ah'. The soft palate of uvula elevate in the midline normally. If there is paralysis, uvula deviates to the side.
X. Vagus	Swallowing, gag reflex, phonation	• Use the tip of a tongue depressor, very gently stimulate the back of the pharynx nose, any asymmetrical contractions of the palate, uvula and pharynx. • Test for swallowing reflex by asking the patient to drink clear fluid to note the reaction.

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Nerve	Function	Assessment
XI. Spinal accessory	Shoulder movement, head rotation	• Assess the *trapezius muscle* function by instructing the patient to raise both shoulder of hold tightly while the examiner applies resistance to both shoulders using hands. • Evaluate the *sternocliedomastoid muscle* function by asking the patient to turn his/ her head against resistance applied by the examiner's hands.
XII. Hypoglossal	Tongue movement, speech articulation	Ask the patient to protrude tongue normally, protrudes in the midline. To assess the tongue strength, instruct the patient to move her tongue to the right or to the left.

Assessment of Motor Function

When assessing motor function from a neurological perspective, the assessment should focus on arm and leg movement. Consider the following:

- Muscle size
- Muscle tone
- Muscle strength
- Involuntary movements
- Posture, gait.

When assessing apply maximum force to the extremity while the patient pushes against the observer's fixed resistance. Use following abbreviations when referring to each extremity:

D – **D**istal
P – **P**roximal
RUE – **R**ight **U**pper **E**xtremity
RLE – **R**ight **L**ower **E**xtremity
LUE – **L**eft **U**pper **E**xtremity
LLE – **L**eft **L**ower **E**xtremity.

Box 3.7: Motor power grading

Grade	Description
5/5	Full range of motion against gravity with extreme resistance
4/5	Full range of motion against gravity with some resistance
3/5	Full range of motion against gravity with no resistance
2/5	Full range of motion with gravity eliminated
1/5	Slight contraction visible
0/5	No movement.

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Assessment of Sensory Function

When assessing sensory function remember that there are three main pathways for sensation and they should be compared bilaterally:

1. Pain and temperature sensation
2. Position sense (*proprioception*)
3. Light touch.

- Touch is assessed by passing a wisp of cotton gently touch various areas on the body, asking the patient to identify the area.
- To assess the pain, gently touch various parts of the body with a sterile needle and request the patient to identify where the sensation is felt.
- Temperature response is evaluated by touching the patient with test tubes filled with warm water and cracked ice alternatively. The patient is asked to distinguish between hot and cold.
- Sense of position is evaluated by instructing the patient to close eyes; the examiner grasp the patients index finger at the last joint from the side of gently raises or lowers it. The patient is asked whether the index finger is positioned up or down. This exercise is repeated using the patient's great toe.

Assessment of Cerebellar Functions

The cerebellum is responsible for muscle coordination and balance on the same side. To test cerebellar function, use the following tests:

- ***Finger to finger test***: The patient is asked to place index finger on the nurse's index finger. This is repeated in succession on both sides.
- ***Finger to nose test***: The patient is asked to extend his/her finger touch the tip of his/her nose several times in rapid succession. This is done with eyes opened eyes closed also.
- ***Patting test***: The patient is asked to hold his/her hands and arms above his/her thighs with palms positioned downward and slap his/her thighs simultaneously. The same is repeated several times in rapid succession with palms positioned upwards also.
- ***Romberg test***: The patient is instructed to stand with feet together, closed eyes and arms at the sides for 10 seconds. The Romberg test is considered positive only if there is actual loss of balance.
- ***Tandem walking test***: The patient is asked to stand in the normal erect, standing position to walk on a straight line. Note any *lurching*, unsteadiness or broadening of gait.

PSYCHOLOGICAL TESTS

Psychological tests are ideally conducted by a clinical psychologist who has been trained in the administration, scoring and interpretation of these tests. This will aid the psychiatrist in diagnosis the disorder. The psychiatric nurse should have knowledge on all these tests, this will enable her to clarify the doubts of the client and family members.

The common psychological tests used are:

Intelligence tests:

- Stanford-Binet test
- Wechsler's adult intelligence test (WAIS)

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- Wechsler's children intelligence test
- Binet kamat test (BKT)
- Bhatia battery test.

Personality test:

- Thematic apperception test (TAT)
- Minnesota multiphasic personality inventory (MMPI)
- 16 PF (16 Personality factor) test
- Draw a person test (DAPT)
- Sentence completion test
- Bender-Gestalt test.

Rating Scales

- Brief psychiatric rating scale (BPRS)
- Scale of assessment of negative symptoms (SANS)
- Scale of assessment of positive symptoms (SAPS)
- Hamilton's anxiety rating scale (HARS)
- Hamilton's depression rating scale (HDRS)
- Yale-Brown obsessive compulsive scale (Y-BOCS).

Role of Nurse in Psychological Tests

The psychiatric nurse should have knowledge about all the above psychological tests. This will enable her to clarify the patients and relatives doubts regarding the psychological tests they have to undergo.

Nurses should have good rapport with the patient of family members. Hence, the patients and relatives are more comfortable approaching the nurse for any clarifications.

The nurse should reassure the patient about the safety of the tests of confidentiality of the observations of the psychologist.

The nurse observes the patient's behavior and the changes, which occur once therapy is commenced. She observes and records the changes in the patient's chart. Better observation is possible by the nurse since the patient is under her care for 24 hours, where as the other team members interact with patient for a limited period of time.

A nurse who is *knowledgeable* and skilled is an empowered nurse who is able to function as per with other team member also.

Box 3.8: Mini-mental status examination (MMSE)

A. Orientation	Score
• What is your age? • What is your occupation? • What day is it today? • Where are you now? • In which ward are you staying? • Which is your native place? • What is the name of this study?	10

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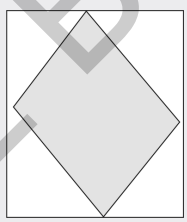
• What is time now? • Which is the current season of the year? • Since how many days are you staying here?	
B. Registration	
Name three objects: One second to say each. Then ask the patient all three after you have said them. Give one point for each correct answer. Repeat them until he learns all the three. Count the trials and record number of trials.	**3**
C. Attention and concentration	
Begin with 100 and count backwards by 7 (stop after 5 answers). Alternatively spell 'WORLD' backwards.	**5**
D. Recall	**3**
Ask for three objects repeated above. Give one point for each other.	
E. Language	
• Show a pencil and a watch, and ask subject to name them. • Repeat the following; 'No ifs, 'ands', or 'buts'. • A three stage command: 'Take a paper in your right hand; fold it in half, and put in on floor'. • Read and obey the following (show subject the written them) **Close your eyes** Write a sentence. Copy a design (For example, complex polygon) 	**2** **1** **3** **1** **1** **1**

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A Concise Textbook of
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NURSING

Salient Features

- The contents of this book are student-friendly and arranged as per INC Syllabus.
- The language used in the text is very simple and easy-to-understand.
- Each psychiatric disorder is covered with separate medical and nursing management.
- A good reference book for all the Nursing Programs.



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