MENTAL HEALTH NURSING · STUDY GUIDE

# Exam 1 Study Guide

This guide covers the first two chapters. You will learn what mental health is, how distress becomes disorder, how stigma shortens lives, and why the words in the chart matter. Then you will learn the therapeutic relationship as a clinical skill: its phases, its techniques, its boundaries, and how to keep it alive through delegation, documentation and escalation. Work one chapter at a time. Read the "what to know" paragraphs, study the tables, then try each worked case with the steps covered. Finish each chapter with its ten self-test items. The cram sheet at the end puts the rules in one place.

**WHAT THIS GUIDE COVERS**

- Chapter 1 · the dual-continuum model, distress versus disorder, how common and how early mental illness starts, the treatment and mortality gaps, risk and protective factors, DSM-5-TR versus the human response, the four forms of stigma, diagnostic overshadowing, the violence myth, person-first language, history, the recovery model, trauma-informed care, therapeutic use of self, the milieu, delegation and red flags with SBAR.
- Chapter 2 · therapeutic use of self and self-awareness, the four phases of the relationship, social versus therapeutic relationships, boundary crossings and violations, transference and countertransference, SOLER, therapeutic techniques and non-therapeutic responses, cultural humility and interpreters, hallucinations and delusions, de-escalation, suicide disclosure, the milieu, delegation, documentation and SBAR.

CHAPTER 1

## Mental Health, Mental Illness and Stigma

Read it in full: **Chapter 1 in the textbook**. Practice it in the lab: **Dual-Continuum Plotter: Distress or Disorder?** and **Rewrite the Chart: Turning Labels into Observations**.

### What to know

Every nurse is a mental health nurse. The person with a broken hip may also be in alcohol withdrawal, and the person with chest pain may have panic disorder, a heart problem, or both. The World Health Organization describes mental health as well-being in which a person realizes their

own abilities, copes with ordinary stress, works productively and contributes to the community. Notice what it is not: it is not "has no diagnosis." It is a positive capacity that varies across a lifetime and even across a week.

The **dual-continuum model** puts mental health and mental illness on two separate axes. One runs from flourishing to languishing. The other runs from no illness to serious illness. So four situations exist. A person with well-managed bipolar I disorder who takes lithium, sleeps, works and is loved is flourishing with an illness. A person with no diagnosis who is isolated, joyless and drifting is languishing without one. Collapse the axes into one line and you make two errors: you think treatment success means silent symptoms, and you miss the undiagnosed person who is quietly disappearing.

Between health and illness sits **mental distress**: grief, adjusting to a diagnosis, the anxiety of a first semester. Distress is a normal response to abnormal circumstances and usually needs presence, sleep, food, structure and time. It becomes a disorder through three things: **duration**, **functional impairment**, and **departure from what the person's own culture would expect**. Grief and depression can coexist.

Mental illness is common and starts young. About one in five adults has a diagnosable disorder in a given year, and close to half will at some point in life. About half of all lifetime disorders begin by age fourteen and three quarters by the mid twenties. The **treatment gap** is the distance between having a disorder and getting adequate care: more than half get none in a given year, often after years of delay. The **mortality gap** is starker: people with serious mental illness die ten to twenty years earlier, mostly from cardiovascular disease, respiratory disease, diabetes and cancer, not suicide.

No single cause explains mental illness. The working model is biopsychosocial, and the **stress-vulnerability model** says each person has a threshold that stressors cross unless buffers hold. Adverse childhood experiences (ACEs) show a dose-response link to later depression, substance use, suicide attempts and even heart disease and COPD. Resilience is learnable. When you plan care you are often adding protective factors, such as one reliable adult, belonging, work, sleep and a person who answers the phone at two in the morning.

Diagnosis in the United States uses the **DSM-5-TR**; internationally the **ICD-11** does the same job and drives billing codes. These are consensus documents: useful, revisable and imperfect. Nursing works one layer over. The medical diagnosis names the disorder; nursing names the **human response**, such as hopelessness, disrupted sleep or risk for self-directed violence. Culture shapes how distress shows up. Somatic complaints such as "my nerves" are a common idiom of distress, and the DSM-5-TR Cultural Formulation Interview asks what the person calls the problem, what caused it and what should help.

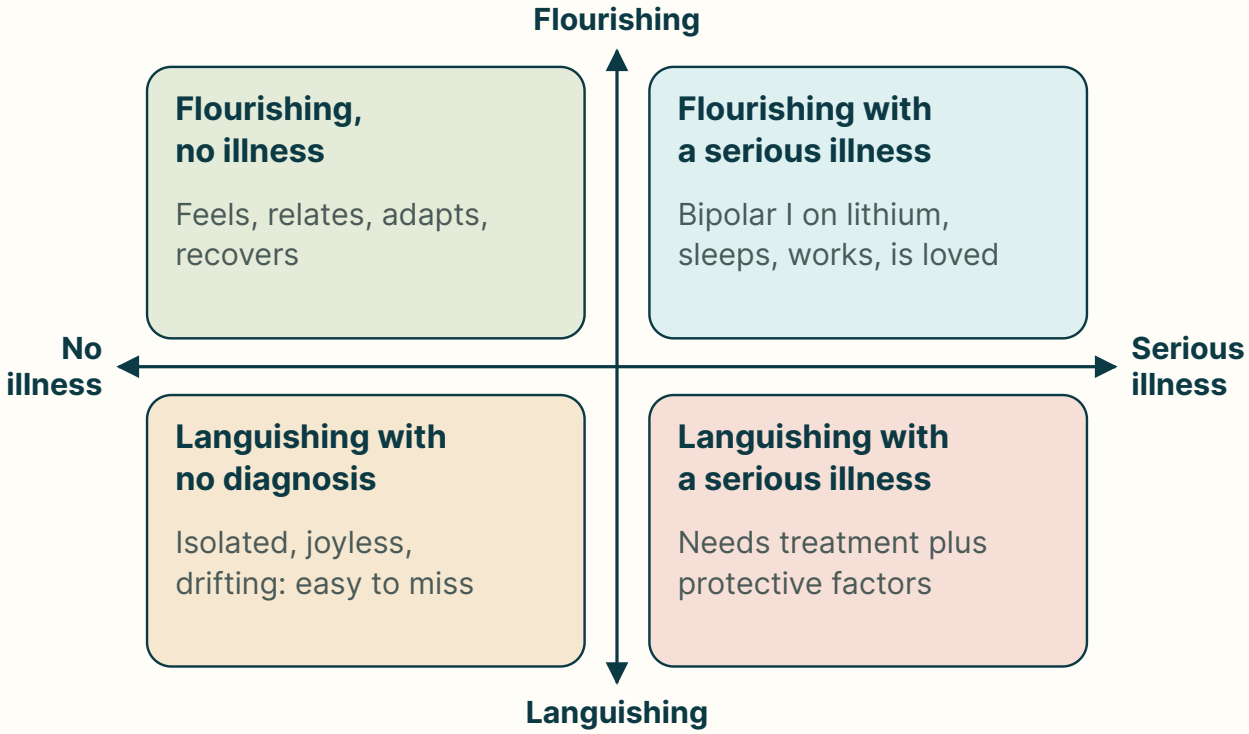
**Stigma** is a chain: a label, a stereotype, prejudice (the stereotype believed) and discrimination (behavior). Facts attack the stereotype; contact with a real person attacks the prejudice, which is why contact-based education works better. Four forms recur: **public**, **self-stigma** (the "why try" effect), **structural** (unequal funding, psychiatric boarding) and **courtesy** stigma toward families and staff. **Label avoidance**, refusing care to avoid the label, may be the biggest driver of the treatment gap. At the bedside the most dangerous form is **diagnostic overshadowing**: blaming new physical symptoms on a known psychiatric diagnosis and stopping the workup.

People with mental illness are far more likely to be **victims** of violence than perpetrators; the share of violence due to serious mental illness alone is a few percent. Language is the part of stigma you control: person-first words, behavior instead of motive labels, and "died by suicide," never "committed." History warns against confident coercion, from asylums to lobotomy to transinstitutionalization into jails. Today care is **recovery-oriented** (CHIME: Connectedness, Hope, Identity, Meaning, Empowerment) and **trauma-informed** (the four Rs and six principles). The relationship and the milieu are the treatment, assessment is never delegated, and every red flag ends in a direct question, a safety action and an SBAR.

**LOCK THESE IN**

- Mental health and mental illness are two axes; a person can flourish with a diagnosis or languish without one.
- Distress becomes disorder by duration, impairment and departure from cultural expectation.
- One in five adults per year; half of disorders start by 14, three quarters by the mid twenties.
- Mortality gap: 10 to 20 years, mostly from physical disease, not suicide.
- Stigma forms: public, self, structural, courtesy; plus label avoidance. Contact beats information.
- Diagnostic overshadowing: a new physical complaint gets the same workup as in anyone else.
- Recovery is not cure: CHIME. Trauma-informed care asks "what happened to you?"
- Restraint is a last resort; assessment, teaching, evaluation and observation level changes are never delegated.

## The dual-continuum model




Up and down: mental health. Left to right: mental illness.

**Two axes, not one line.** Because health and illness are separate, a person can flourish with a diagnosis or languish without one. Treating them as one line hides the undiagnosed person who is quietly disappearing.

## Stigma, recovery and trauma-informed care at a glance

| Term | What it means | At the bedside |
|---|---|---|
| **Public stigma** | What the community believes about people with mental illness | Correct myths out loud, such as the violence myth |
| **Self-stigma** | Public beliefs turned inward: shame, secrecy, "why try" | Listen for "what is the point of applying?" |
| **Structural stigma** | Stigma built into systems: funding, networks, boarding | A three day wait in an ED hallway for a bed |
| **Courtesy stigma** | Stigma carried by families and mental health staff | Families and psych nurses feel it too |
| **Label avoidance** | Declining care to avoid the label | A large driver of the treatment gap |
| **Diagnostic overshadowing** | Blaming new physical symptoms on the psychiatric diagnosis | Chest pain still gets an ECG |
| **Recovery (CHIME)** | Connectedness, Hope, Identity, Meaning, Empowerment | Work from the person's own goals |
| **Four Rs** | Realize, recognize, respond, resist re-traumatization | Assume a trauma history may be present |
| **Six principles** | Safety; trust and transparency; peer support; collaboration; voice and choice; cultural, historical and gender issues | Say what you will do before you do it |

## Say this, not that

| Do not say | Say instead | Why |
|---|---|---|
| **A schizophrenic; a borderline** | A person with schizophrenia | The diagnosis is something a person has |
| **An addict; an abuser** | A person with a substance use disorder | "Abuser" leads to more punitive responses |
| **Clean or dirty urine** | Negative or positive toxicology screen | No moral framing of a lab result |
| **Committed suicide** | Died by suicide | Removes crime and sin connotations |
| **He was committed** | He was admitted involuntarily | Names the legal status, not a punishment |
| **Non-compliant** | Has not been taking the medication; barriers named | Prompts the real question |
| **Manipulative; attention-seeking** | The observed behavior, with time and context | Observable and points to an unmet need |
| **Drug-seeking** | Reports pain 8 of 10 and requests opioid medication | Prevents undertreated pain |

## Worked cases

**WORKED CASE 1 · DISTRESS OR DISORDER?**

Dana, 20, failed a chemistry exam two weeks ago. She cried for two days, then studied with friends and passed the retake. Her roommate Leah, 21, has felt empty for two months, stopped going to class, sleeps twelve hours, has lost interest in everything, and says she is worthless. Which picture is distress and which suggests disorder?

**STEP 1 · CHECK DURATION**

Dana: days, in proportion to the trigger. Leah: two months and growing.

**STEP 2 · CHECK IMPAIRMENT**

Dana is back in class and functioning. Leah has stopped attending class and self-care is slipping.

#### STEP 3 · CHECK CULTURAL EXPECTATION

Tears after a failed exam are an expected response in Dana's community. Two months of worthlessness and loss of interest are not.

#### STEP 4 · DECIDE

Dana shows **distress**, which needs time, support and structure. Leah shows features of a **disorder** and needs assessment, including a direct question about suicide.

#### WHY IT MATTERS

Worthlessness plus loss of interest plus impairment is the pattern that must be screened for suicidal thinking, not reassured away.

### WORKED CASE 2 · REWRITING A NOTE

A note reads: "Pt is manipulative and attention-seeking, a borderline. Non-compliant with meds. Clean UDS." Rewrite it the way the chapter teaches.

#### STEP 1 · FIND THE MOTIVE LABELS

"Manipulative," "attention-seeking" and "non-compliant" are guesses about motive, not findings.

#### STEP 2 · FIND IDENTITY AND MORAL WORDS

"A borderline" makes the diagnosis the person. "Clean" is moral vocabulary for a lab result.

#### STEP 3 · REPLACE WITH BEHAVIOR

"Requested to speak with a nurse six times this shift; requests rose in volume when the unit became busy."

#### STEP 4 · REPLACE THE REST

"Has not taken the evening dose for three days; states the medication makes her too tired to work. Toxicology screen negative. Diagnosis of borderline personality disorder."

#### CHECK IT

Every phrase is now something another nurse could observe and act on, and nothing judges motive.

### WORKED CASE 3 · DIAGNOSTIC OVERSHADOWING

Mr. Okafor, 46, lives with schizophrenia. He reports new abdominal pain. A colleague says, "That is just his somatic stuff." What do you do?

#### STEP 1 · NAME THE RISK

Blaming a new physical complaint on a known psychiatric diagnosis is diagnostic overshadowing, and it feeds the mortality gap.

#### STEP 2 · APPLY THE RULE

Any new physical complaint gets the same workup it would get in a person with no psychiatric diagnosis.

**STEP 3 · ASSESS**

Full vital signs, pain assessment, abdominal exam findings, bowel habits, intake.

**STEP 4 · ESCALATE**

Report findings to the provider with a specific request for evaluation. Document his own words.

**SAME IDEA, OTHER SETTINGS**

New confusion or agitation in an older adult, or in a person with intellectual disability, is a medical event until proven otherwise.

**WORKED CASE 4 · AN SBAR THAT GETS ACTION**

Ms. Salcedo, 58, admitted for depression two days ago, tells you she has thoughts of killing herself and you find twelve saved tablets in her drawer. Build the call.

**STEP 1 · ACT FIRST**

Do not leave her alone. Start continuous observation and secure the tablets.

**STEP 2 · SITUATION**

"This is Jordan, RN on 3 East, about Ms. Salcedo in room 8. In the last thirty minutes she told me she is thinking of killing herself and has been saving tablets."

**STEP 3 · BACKGROUND**

"She is 58, admitted two days ago with major depressive disorder, one prior attempt, lives alone."

**STEP 4 · ASSESSMENT**

"She has a plan and means; I found twelve tablets. She rates her intent as strong. Vital signs stable. She is on continuous observation now and the tablets are secured."

**STEP 5 · RECOMMENDATION**

"I need you to see her within the hour to reassess risk and observation level, and I would like an order for mouth checks with every dose. Can you come now?"

**WHAT IS MISSING ON PURPOSE**

No guesses about motive. Only what was said, found, done and needed.

**TRAPS PEOPLE FALL INTO**

- **Treating "no diagnosis" as "mentally healthy."** The dual continuum says a person can languish with no diagnosis at all.
- **Thinking suicide is the main cause of the mortality gap.** Cardiovascular disease, respiratory disease, diabetes and cancer lead it.
- **Believing mental illness predicts violence.** People with mental illness are far more often victims. History of violence, substance use and lethal means predict violence for everyone.

- **Charting motive.** "Manipulative," "attention-seeking," "drug-seeking" and "non-compliant" are inferences, not findings.
- **Calling recovery a cure.** A person can be in recovery while hearing voices if they have hope, meaning, connection and control.
- **Asking for the trauma story.** You do not need the details to act on the answer, and asking for more than you can contain can harm.
- **Delegating judgment.** Assistive personnel may sit 1:1 and report; they may not change the observation level or screen for suicide.
- **Celebrating sudden calm.** Sudden cheerfulness after deep depression is a red flag. Reassess suicide directly.

## Chapter 1 self-test · ten items

### 1. A man with no psychiatric diagnosis has felt joyless, isolated and aimless for months. Where does the dual-continuum model place him?

A. At the midpoint of a single health line
B. Mentally healthy, because no illness is present
C. Languishing, without a mental illness
D. Flourishing, because he has no diagnosis

**C. Languishing, without a mental illness** The two axes are separate. A person can languish with no diagnosis, and that person is easy to miss.

### 2. Which set of features marks the point where distress becomes a mental disorder?

A. A request for help, poor sleep and a low appetite for weeks
B. Duration, impairment and departure from cultural expectation
C. Number of symptoms, age of onset and need for medication
D. Intensity of crying, family history and a recent stressor

**B. Duration, impairment and departure from cultural expectation** The chapter names exactly three: how long it lasts, whether it impairs function, and whether the person's own culture would expect it.

### 3. What causes most of the shortened life expectancy in people with serious mental illness?

A. Physical diseases such as heart disease and diabetes
B. Suicide, which accounts for most of the early deaths
C. Violence committed against others in the community
D. Accidental overdose of prescribed antipsychotics

**A. Physical diseases such as heart disease and diabetes** The leading causes are cardiovascular disease, respiratory disease, diabetes and cancer, driven by smoking, metabolic side effects, poverty and missed physical care.

### 4. A client says, "Why bother applying for that job? People like me never get hired." Which form of stigma is this?

A. Structural stigma (systems)
B. Public stigma (community)
C. Courtesy stigma (by association)
D. Self-stigma (internalized)

**D. Self-stigma (internalized)** Self-stigma is public belief turned inward, producing the "why try" effect.

### 5. A client with panic disorder reports crushing chest pain. The nurse thinks, "It is probably another panic attack." What is the risk?

A. Label avoidance by the nurse during assessment
B. Countertransference toward an anxious client
C. Diagnostic overshadowing of a possible cardiac event
D. Courtesy stigma directed at the client's family

**C. Diagnostic overshadowing of a possible cardiac event** Overshadowing attributes a new physical symptom to the psychiatric diagnosis. Chest pain still gets an ECG and a full workup.

### 6. Which anti-stigma approach does the chapter say changes attitudes most durably?

A. Contact with a person who has lived experience
B. Printed fact sheets about prevalence rates
C. Protest campaigns aimed at news coverage
D. Lectures on the history of asylum care

**A. Contact with a person who has lived experience** Facts attack the stereotype, but contact attacks the prejudice. Protest alone can backfire.

### 7. Which charting entry is written correctly?

A. "Manipulative with staff whenever limits were set this evening."
B. "Called staff five times in one hour; states she fears being alone."
C. "Non-compliant and difficult during evening care and meds."
D. "Attention-seeking behavior noted throughout the entire shift."

**B. "Called staff five times in one hour; states she fears being alone."** It names observable behavior and the person's own words. The others are motive labels.

### 8. What does the "C" in CHIME stand for in the recovery model?

A. Compliance
B. Consistency
C. Containment
D. Connectedness

**D. Connectedness** CHIME is Connectedness, Hope and optimism, Identity, Meaning and purpose, and Empowerment.

**9. On a behavioral unit, which assignment fits assistive personnel?**

A. Continuous 1:1 observation once trained and directed
B. Deciding to downgrade a client's observation level
C. Screening a new admission for suicide risk on arrival
D. Teaching a client about a newly prescribed medication

**A. Continuous 1:1 observation once trained and directed** Trained assistive personnel may observe and report. Changing the level, screening and teaching stay with the nurse.

**10. After two weeks of deep depression, a client is suddenly cheerful and gives away her books. What is the priority action?**

A. Praise the progress and begin planning for early discharge
B. Document improvement and reduce the observation level
C. Ask the provider to lower the antidepressant dose today
D. Reassess suicidal ideation directly and increase observation

**D. Reassess suicidal ideation directly and increase observation** Sudden calm and giving things away may mean a decision to die. Ask directly, increase observation and report.

CHAPTER 2

# The Therapeutic Relationship and Communication

Read it in full: **Chapter 2 in the textbook**. Practice it in the lab: **The Therapeutic Frame: Phases and Boundaries** and **Say-It Bench: The Reply That Keeps the Door Open**.

## What to know

In most of nursing the relationship delivers the treatment. In mental health nursing the relationship **is** the treatment. Hildegard Peplau described nursing as an interpersonal process, and the deliberate use of your presence and responses for the patient's benefit is **therapeutic use of self**. It

is not "being nice." Every choice, sitting or standing, speaking or staying quiet, should be justifiable on clinical grounds afterward.

Because you are the tool, the tool must be calibrated. **Self-awareness** is built by three habits: notice the body (tight chest, faster voice, wanting to leave), name the feeling privately, and take it to supervision or debriefing. Experienced nurses still have reactions; they just catch them faster.

The relationship has four phases. **Preinteraction**: the patient is not yet present; review the chart, plan, and examine your own expectations. **Orientation**: name and role, purpose, confidentiality and its limits, assessment, mutual goals and a stated end point. Say a legal admission status plainly. **Working**: explore problems, try new coping; resistance and testing appear here. **Termination**: review gains, name feelings about ending, link to follow up. Termination starts in orientation, when you say the relationship has an end.

A social relationship is mutual. An intimate relationship adds exclusivity. A therapeutic relationship is deliberately one-directional and time-limited. A **boundary crossing** is a brief, often kind step outside the frame: a small gift, a personal detail, staying late for one patient. A **boundary violation** is exploitative: romantic or sexual contact, money, social media contact, keeping a secret from the team. Violations come at the end of a chain of unexamined crossings. **Transference** is the patient redirecting feelings from a past figure onto you; **countertransference** is your reaction shaped by your history. Name it, take it to supervision, do not act on it.

Most of the message is nonverbal. **SOLER**: Sit squarely or at a slight angle, Open posture, Lean in slightly, comfortable Eye contact, Relax. In mental health a slight angle is usually better than face-on, and eye contact follows the person's lead. Sit down: patients think a seated nurse stayed longer. Keep both of you clear of the door and give extra space in acute distress. When words and body disagree, people believe the body.

Therapeutic techniques keep the focus on the person: offering self, broad openings, open-ended questions, reflecting, restating, clarifying, silence, focusing, exploring, making observations, presenting reality, seeking consensual validation, summarizing and voicing doubt. Non-therapeutic responses relieve the nurse: false reassurance, advice, "why" questions, defending,

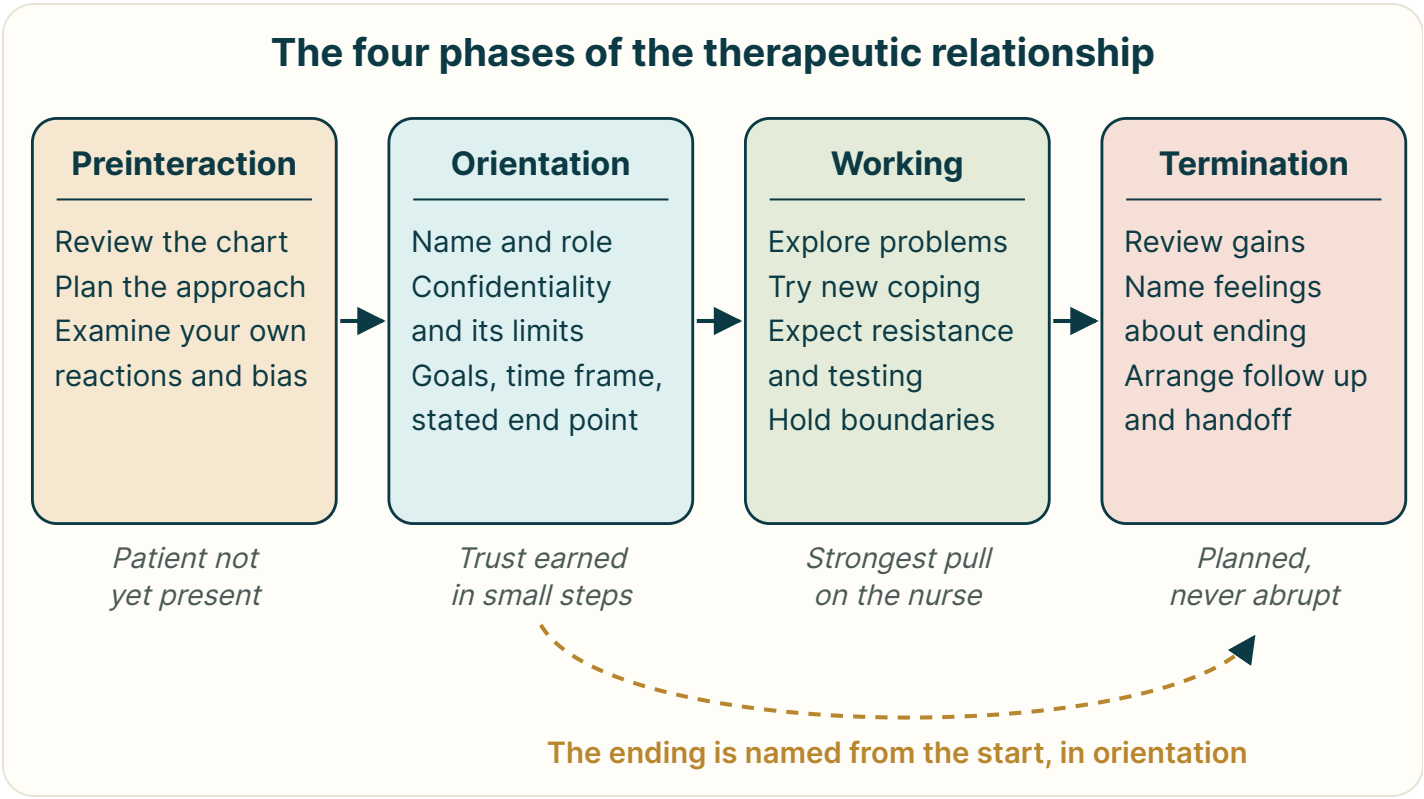
disapproval, arguing with a delusion, clichés. The method in one line: **do not correct the content, follow the feeling**.

Practice as though a trauma history is present: explain before acting, offer real choices, ask before touching. **Cultural humility** is lifelong curiosity and awareness of the power imbalance. Use a qualified medical interpreter, never family and never children. In hard moments: count to ten before breaking a silence; with hallucinations, neither argue nor collude ("I do not hear the voices, and I believe that you do"); with anger, de-escalate at the prodrome, one speaker, low slow voice, two arm lengths, choices and limits on behavior, not the person.

When someone hints at suicide, ask directly: "Are you thinking about killing yourself?" Asking does not plant the idea. Stay with the person and never promise a secret in advance. The milieu is treatment, and inconsistency among staff is anti-therapeutic. Delegate only routine tasks for stable patients, with exact instructions, and keep assessment, teaching and evaluation. Chart quotations and interventions, not impressions. Escalate red flags in SBAR with "I am concerned" and a specific request with a time frame.

**LOCK THESE IN**

- Phases: preinteraction, orientation, working, termination. Termination is named in orientation.
- Crossing is brief and kind; violation is exploitative. Secrets kept from the team are violations.
- Countertransference is data about the nurse: notice, supervise, do not act on it.
- SOLER, with a slight angle and eye contact that follows the person's lead.
- Wrong-answer words: why, should, do not worry, everyone, promises about the future.
- Hallucinations: present reality, validate the feeling, ask what the voices say.
- Never accept a secret in advance; state confidentiality limits in orientation.
- Interpreter: qualified, never family, never children; speak to the patient.




**A relationship with a plan.** Each phase has its own nursing task. The step students skip is the self examination in preinteraction, and the error that hurts most is an ending nobody planned.

## Techniques and why they work

| Technique | Sounds like | Why it works |
|---|---|---|
| **Offering self** | "I will sit here with you for a while." | Presence without demand |
| **Broad opening** | "What would you like to talk about?" | Hands the person the agenda |
| **Open-ended question** | "What has the last week been like?" | Gets their words, not yours |
| **Reflecting** | "You sound frightened about going home." | Names a feeling so it becomes manageable |
| **Restating** | "You have not slept more than two hours." | Confirms you heard it right |
| **Clarifying** | "Can you walk me through what happened first?" | Prevents a plan built on a misunderstanding |
| **Silence** | Several quiet seconds | Room to reach the harder sentence |
| **Focusing** | "You mentioned your brother twice." | Moves toward what matters |
| **Making observations** | "I notice you have been pacing since the call." | Opens a topic without accusing |
| **Presenting reality** | "I do not hear a voice, but I believe you do." | Neither argues nor colludes |
| **Consensual validation** | "When you say wired, what does that feel like?" | Shared meaning of words |
| **Summarizing** | "So the sleep, the money and the court date." | Lets the person hear the whole picture |

## Non-therapeutic responses and what they do

| Response | Example | What it does |
|---|---|---|
| **False reassurance** | "Of course you can, you are doing great!" | Teaches the person to stop reporting |
| **Advice** | "You should just call them and apologize." | Makes the nurse the expert on their life |
| **Why question** | "Why would you do that?" | Demands justification; defensiveness |
| **Defending** | "That is not true, we work hard for you." | Protects the team's image |
| **Disapproval** | "Do not say that about yourself." | Shame becomes unspeakable |
| **Arguing with a delusion** | "There are no cameras, look." | Cannot win; costs trust |
| **Cliché, minimizing** | "Everything happens for a reason." | Ends the moment the work began |

## Worked cases

**WORKED CASE 1 · CHOOSING THE REPLY**

A man admitted after an overdose says, "You all just want me out of here so you can free up the bed." Choose and justify a reply.

**STEP 1 · SPOT THE REFLEX**

"That is not true at all" is defending. It protects the institution and closes the topic.

**STEP 2 · FIND THE FEELING**

Under the accusation is worry about being sent out before he is ready.

**STEP 3 · ANSWER THE FEELING**

"It sounds like you are worried you will be sent out before you are ready. Tell me what going home looks like to you."

**STEP 4 · SEE WHAT IT OPENS**

He describes an empty apartment and a landlord who has served notice: two risk factors for discharge planning.

**THE RULE**

Follow the feeling, not the content. The complaint became an assessment.

### WORKED CASE 2 · THE SECRET

During your second meeting, a woman says, "I will tell you something, but only if you promise not to tell anyone." What do you say, and when should this have been handled?

#### STEP 1 · DO NOT PROMISE

A promise of secrecy cannot be kept if the content is about harm, and it splits the team.

#### STEP 2 · STATE THE LIMIT

"I cannot promise that. Anything about you or someone else being hurt I have to share with the team so we can keep you safe. Everything else stays between us."

#### STEP 3 · KEEP THE DOOR OPEN

"I would still like to hear what is on your mind."

#### STEP 4 · LOOK BACK

The limits of confidentiality belong in the **orientation** phase, so this moment is already handled.

#### WHY HONESTY WORKS

Honest limits build more trust than false ones.

### WORKED CASE 3 · VOICES AND THE FOOD

Mr. Tran, 33, says, "The voices are telling me the staff are poisoning the food." He has not eaten today.

#### STEP 1 · AVOID BOTH ERRORS

Do not argue ("there are no voices") and do not collude ("I will check the food for you").

#### STEP 2 · PRESENT REALITY AND VALIDATE

"I do not hear those voices, and I believe that you do. That must be frightening."

#### STEP 3 · SCREEN FOR COMMANDS

"Are the voices telling you to do anything?" This is a safety assessment, not curiosity.

#### STEP 4 · ACT ON INTAKE

Offer sealed or packaged food, note intake, and report the refusal and the content to the provider.

#### IF THE VOICES COMMAND HARM

Command hallucinations to harm self or others need increased observation and immediate escalation.

### WORKED CASE 4 · DELEGATING 1:1 OBSERVATION

You need assistive personnel to sit with Mr. Adeyemi, who is on continuous observation. Turn "watch him" into a real delegation.

#### STEP 1 · RIGHT TASK AND PERSON

Continuous observation is delegable once the nurse has set the level and the staff member is trained.

#### STEP 2 · RIGHT DIRECTION

"He is on continuous one-to-one visual observation, within arm's length, including in the bathroom."

#### STEP 3 · WHAT TO REPORT

"Tell me right away if he refuses to eat, talks about the voices, or tries to enter another room."

#### STEP 4 · RIGHT SUPERVISION

"I will check in every thirty minutes." Then do it, and evaluate.

#### WHAT STAYS WITH YOU

Changing the observation level, assessing risk and teaching never transfer.

#### TRAPS PEOPLE FALL INTO

- **Skipping preinteraction self-examination.** Reading "third admission this year" and losing interest is exactly what this phase catches.
- **Promising confidentiality without limits.** Limits are stated in orientation, before any secret is offered.
- **Calling every step outside the frame a violation.** A small gift is a crossing; romantic contact, money and secrets from the team are violations.
- **Picking the "why" option.** Why questions demand justification. Ask what was going on instead.
- **Facing a frightened person squarely.** A slight angle reads as less confrontational, with a clear exit for both.
- **Using a family member to interpret.** You cannot screen for suicide, abuse or substance use honestly through family. Never use children.
- **Filling silence.** Count to ten. If you must speak, make an observation, not a question.
- **Agreeing that you are "the only nurse who cares."** That splits the team. Say everyone is working on the same plan.

## Chapter 2 self-test · ten items

### 1. In which phase does the nurse examine personal reactions before meeting the client?

A. Termination
B. Orientation
C. Preinteraction
D. Working phase

**C. Preinteraction** Preinteraction happens before contact: chart review, planning, and checking your own expectations and bias.

### 2. When should the nurse first tell a client the relationship will end?

A. Only if the client asks about it
B. During orientation, at the start
C. During the working phase, after trust forms
D. In the last session before discharge

**B. During orientation, at the start** Termination begins in orientation, when the nurse states a time frame and an end point.

### 3. A nurse wants to know which act crosses into a violation. Which one is it?

A. Sharing that you also like gardening
B. Staying five minutes late to finish a talk
C. Accepting a small handmade card
D. Keeping a client's secret from the team

**D. Keeping a client's secret from the team** Keeping secrets from the treatment team is a violation. The others are crossings to bring to supervision.

### 4. A nurse feels dread before entering one client's room every shift. What does this most likely represent?

A. Countertransference to take to supervision
B. A finding to document in the client's chart
C. Transference that the client must work on
D. A sign the client should be transferred

**A. Countertransference to take to supervision** Intensity out of proportion is the tell of countertransference. It is data about the nurse, not the patient.

### 5. During a check-in, a client mentions he quit his medication three weeks back. Which reply is therapeutic?

A. "You should restart it today before it gets worse."
B. "Do not worry, the doctor will fix the dose."
C. "What was going on around the time you stopped?"
D. "Why would you stop a medication that helps?"

**C. "What was going on around the time you stopped?"** An exploring question gets side effects, cost, stigma or feeling well. The others are a why question, advice and false reassurance.

### 6. A client says, "There are cameras in the vents watching me." Which reply is best?

A. "I will ask maintenance to check every vent today."
B. "There are no cameras in this room, come and look."
C. "Let us not talk about the cameras right now, okay?"
D. "I do not see cameras; being watched sounds scary."

**D. "I do not see cameras; being watched sounds scary."** Present reality and validate the emotion. Arguing cannot win and checking colludes.

### 7. Which nonverbal approach does the chapter recommend for a frightened or paranoid client?

A. Sit at a slight angle with a clear path to the door
B. Hold steady, direct eye contact for the whole talk
C. Sit close and rest a hand on the client's arm
D. Stand squarely in front of the client at all times

**A. Sit at a slight angle with a clear path to the door** An angle reads as less confrontational, eye contact follows the person's lead, and touch is avoided.

### 8. A client who speaks Vietnamese is admitted with her 12-year-old son. Who should interpret?

A. Her husband by speakerphone
B. A qualified medical interpreter
C. Her son, since he is fluent
D. Any bilingual staff member nearby

**B. A qualified medical interpreter** Use a qualified interpreter. Never family and never children; they block honest screening.

### 9. A client's voice is rising and he is pacing near the door. What is the first action?

A. Call for restraint now, before he escalates further
B. Tell him to calm down or he will lose privileges
C. Surround him with several staff members at once
D. Begin verbal de-escalation with space and a calm voice

**D. Begin verbal de-escalation with space and a calm voice** The prodrome is where de-escalation works. One speaker, low and slow, space and choices.

**10. Which note would help the next nurse most?**

A. "Patient appeared hopeless and difficult this shift."
B. "Gave support; patient seemed to feel better after."
C. "Sat with her 20 min; she described fear of going home."
D. "Encouraged patient to verbalize her feelings today."

---

**C. "Sat with her 20 min; she described fear of going home."** Chart the intervention and the person's words, not an impression. The others tell the next nurse nothing.

ONE PAGE

# Cram sheet

Everything from chapters 1 and 2 in one place. Cover the right column and see if you can rebuild each row.

## Numbers to know

| Item | Value | Note |
|---|---|---|
| **Adults with a disorder in a year** | About 1 in 5 | Close to half over a lifetime |
| **Age of onset** | Half by 14; three quarters by mid twenties | Early intervention buys back years |
| **Treatment gap** | More than half get no care in a year | Delays of years are typical |
| **Mortality gap** | 10 to 20 years earlier | Mostly physical disease |
| **Violence share** | A few percent due to serious mental illness alone | Far more often victims |
| **State hospital census** | Fell by more than 90% | Transinstitutionalization followed |
| **Key dates** | Chlorpromazine 1952; Community Mental Health Act 1963 | Community centers never fully funded |
| **Alcohol withdrawal clock** | Signs 6 to 24 h; seizures 12 to 48 h; DTs 48 to 96 h | Benzodiazepines; CIWA-Ar |
| **Personal space in de-escalation** | At least two arm lengths | Angled, hands visible, exit clear |
| **Silence** | Count to ten before breaking it | Break it with an observation |

## Frameworks

| Framework | The parts |
|---|---|
| **Dual continuum** | Flourishing to languishing; no illness to serious illness |
| **Distress to disorder** | Duration, impairment, departure from cultural expectation |
| **Stigma chain** | Label, stereotype, prejudice, discrimination |
| **CHIME** | Connectedness, Hope, Identity, Meaning, Empowerment |
| **Four Rs** | Realize, recognize, respond, resist re-traumatization |
| **Phases** | Preinteraction, orientation, working, termination |
| **SOLER** | Sit angled, Open, Lean in, Eye contact, Relax |
| **Five rights of delegation** | Task, circumstance, person, direction and communication, supervision and evaluation |
| **SBAR** | Situation, Background, Assessment, Recommendation |

## Rules that keep people safe

| Topic | The rule |
|---|---|
| **Suicide** | Ask directly in plain words; stay with the person; remove means; escalate. |
| **Secrets** | Never accept one in advance; limits stated in orientation. |
| **New physical symptom** | Same workup as anyone else; delirium is a medical emergency. |
| **Language** | Person-first, behavior not motive, "died by suicide." |
| **Restraint** | Last resort after de-escalation, least restrictive, shortest time. |
| **Delegation** | Routine tasks for stable patients; never assessment, teaching, evaluation or observation level. |
| **Escalation** | Act first, then call; say "I am concerned" and ask for something with a time frame. |

Dr. Garg Learning · CC BY-SA 4.0