

PATIENT CARE IN PSYCHIATRY

PART OF THE FOUNDATIONS OF PSYCHIATRY INDEPENDENT LEARNING PROGRAM

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Foundations of Psychiatry: Patient Care in Psychiatry

Introduction/Purpose Statement

Staff who are entering into the psychiatric care setting need to have all kinds of information so that they can deliver optimal care without falling into the pitfalls that may loom before them. The Foundations of Psychiatric Care home study series was developed by expert staff from Hennepin County Medical Center, the Minneapolis VA Medical Center, and Regions Hospital to get this information out in an easy-to-read, practical, and relevant manner. This program is divided into four sections: I) Introduction; II) Patient Care; III) Safety; and IV) Interventions. The purpose of the *Patient Care in Psychiatry* module (this home study) is to review issues concerning professional boundaries, confidentiality, therapeutic milieu, and therapeutic relationships/communication.

Target Audience

We developed this program to provide the information necessary to care for the psychiatric patient. The sections were written for the person who has not worked in psychiatry before; however, more experienced psychiatry staff may find the information useful and interesting.

The sections in this module are applicable to all health care workers.

Content Objectives

1. Identify the purposes of boundaries in patient and staff interactions in the psychiatric setting.
2. Define concepts related to boundaries.
3. Review standards and guidelines related to boundaries.
4. Identify risk factors that contribute to boundary violations.
5. Review legal mandates for confidentiality of patient information.
6. Identify situations in which confidentiality may be breached.
7. List information not to be released regarding psychiatric patients.
8. List information which should not be accessed related to patient confidentiality.
9. Describe the elements necessary in a therapeutic milieu.
10. State the role of each staff member in providing and managing a therapeutic milieu.
11. Differentiate between a social and professional relationship.

12. Explain the elements of a therapeutic relationship.
13. Describe elements that are not part of the therapeutic relationship.
14. Describe the elements of therapeutic communication.
15. Identify the therapeutic use of "self."
16. Define the terms "transference" and "countertransference."

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Continuing Education Information

<p>For completing this Home Study and evaluation, you are eligible to receive:</p>	<p>2.0 MN Board of Nursing contact hours / 1.66 ANCC contact hours</p> <p><i>Criteria for successful completion:</i> You must read the home study packet, complete the post-test and evaluation and submit them to TCHP for processing.</p>
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BOUNDARIES

Introduction

We go into helping professions because we care, but sometimes we can help too much or get so involved that our role gets confused or lost. Boundaries exist to keep our focus clear and therapeutic. The often chronic and intense nature of psychiatry has the potential of putting us into relationships which may not be therapeutic. We all "cross the line" from time to time, but our awareness of healthy boundaries and risk factors for unhealthy ones can help to avoid burn-out and decrease boundary crossings and violations. Patients are vulnerable. Staff must provide care that does not harm the patient.

Differences in Relationships

Personal

- Not paid
- Not service oriented
- Open-ended
- Spontaneous
- Power is shared
- Meets needs of both involved
- Choice to be involved
- Shared responsibility
- Casual
- May be sexual
- Boundaries are negotiated

Health Care Provider

- Paid
- Service-oriented
- Time-limited
- Structured
- Asymmetry in power
- Only meets patient's needs
- No choice from staff
- Increased responsibility of staff
- Goal-directed
- Is never sexual
- Boundaries are strictly kept

"In making the decision to be a human services professional, one simultaneously chooses to take on certain responsibilities and loses certain options." (Milgrom, 1983)

Definitions

Therapeutic relationship: an ongoing interactive process that encompasses the philosophy of care, empowerment of the health care provider, and empowerment of the family. The goal is to have caring, well-defined boundaries between the nurse, patient, and family; boundaries that are positive and professional, and that promote patient/family control over health.

Boundaries are limits that protect the space between the HCP's power and the patient's vulnerability. Boundaries provide a framework for the patient/staff relationship. The goal of healthy boundaries is to enable control of the power differential and allow for a safe connection between the HCP and the patient based on the patient's needs. Defining boundaries is a constant challenge.

Dual relationship means having more than one type of relationship with the same person. An example of this would be working as the in-patient nurse for your neighbor. Health providers should not care for a patient with whom they have a pre-existing relationship because it is difficult to act in an unbiased/non-judgmental manner due to the pre-existing relationship. This may lead to boundary issues.

Purposes of Boundaries

- makes the relationship professional by setting the parameters within which professional services are delivered
- defines a healthy relationship that lowers the risk to the patient
- protects patient vulnerability
- protects staff from becoming "lost" or over-involved with the patient
- enables the building of trust and credibility
- keeps the focus on the patient
- provides legal protection for the patient and staff
- protects the space that must exist between staff and patient by maintaining the power differential
- helps keep balance in the HCP's life
- makes for good treatment
- provides a safe environment for the patient

Boundary issues exist on a continuum from boundary challenges to boundary violations. Most boundary transgressions start out with good intentions on the part of staff. While boundary violations are clearly harmful to the patient and may be unethical or illegal, many boundary issues fall into the gray area which must take the situation and consequences of the action into consideration. This gray area is what makes developing healthy boundaries challenging, as there are few clear-cut rules.

Boundary Challenges

These are frequently encountered situations with high potential for boundary crossings or violations. Examples of this would be a patient asking for your home phone number, a patient asking you to pick up some cigarettes for him at the store, or a family member giving you a gift at Christmas.



Boundary Crossings

These are situations where the limits or boundaries of the relationship are altered, which may lead to ambiguity in the relationship. These may be salutatory, neutral, or harmful to the patient. These take into account the context and situation. Examples of boundary crossings would be you attending a patient's funeral, giving out your home phone number to a patient, or doing personal favors for the patient.



Boundary Violations

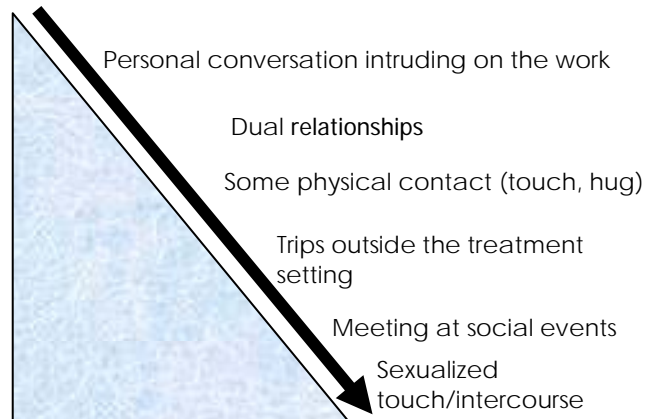
Boundary violations are **always** harmful to the patient and alter the limits of the relationship. They exploit the patient in some way and may cause pain long after the violation occurred. Boundary violations often begin with good intentions (crossings). Examples of violations would be: accepting deals in business transactions with patients (HCPs can never do this; they must pay market price), deliberate socialization, excessive self-disclosure, a breach of patient confidentiality, the use of favors or services from the patient, or sexualized touch.



A boundary violation:

- may cause the patient to have less trust in health (psychiatric) profession
- may discourage the patient from seeking help in the future
- may disrupt other relationships (both professional and personal)
- may precipitate psychiatric disorders
- may increase patient dependency rather than promote independence
- may cause the patient to blame him/herself
- may result in a delayed traumatic stress response
- meets the needs of the nurse
- exploits the patient

It is documented that there is a slippery slope of boundary transgressions. The common path of progression is:



Excessive self-disclosure is the most common boundary violation precursor to excessive intimacy with patients.

Warning Signals/Risk Factors for Health Care Providers

- attraction to a patient
- over-identification with a patient
- patients with uniquely similar personal situations
- stress in staff's life
- an "us vs. them" mindset
- situations with prolonged or intense relationships
- telling the patient that they are your favorite or special
- talking about other patients with that patient
- giving presents to a patient
- flirtations
- the nurse communicates selective information to other staff
- frequently thinking about the patient while not at work
- spending too much time with the patient
- keeping secrets with the patient
- giving special attention or treatment to the patient
- sharing personal information or concerns with the patient

Think about whether or not you would do a certain thing for all of your patients. If the answer is "no," then it is probably a boundary issue. Also, pay attention to how you are feeling; trust your instincts. If your gut is telling you not to do something -- LISTEN!

The first step to healthy boundaries is awareness. We are all at risk for committing boundary transgressions, and we will all commit them at some time or other. We must be aware of risky behaviors, our strengths and weakness, our privileges and responsibilities, and the effects of our actions. The patient may attempt to breach boundaries; staff must always define and maintain boundaries.

Preventative Interventions (Adapted from Pilette, et. al.)

1. Always clarify the role of the staff, set patient goals with the patient at the time of admission, and explain the role of each staff.
2. Review current policies and ethical codes.
3. Explore reasons if a patient is attempting to gain more attention.
4. Balance emotions with clinical judgments.
5. Resist flattery and flirtation.
6. Be aware of your personal limits and usual behaviors.
7. Assist peers who may be evidencing boundary relaxation.
8. Separate therapeutic goals from personal goals.
9. Retain a sense of priority and purpose.
10. Share boundary violation risks with others by writing articles or bulletins.
11. Avoid non-therapeutic self-disclosures.
12. Reflect on how your actions or behaviors may change another person's relationship with that patient.
13. Reflect on the possible outcomes of your actions or behaviors -- negative or positive. Pay attention to your "iffy" situations.
14. Keep social and emotional needs away from work.
15. Respect the patient's dignity.
16. Reflect on how other staff members will perceive your intentions.

Reporting and Documenting

This is governed by licensing boards (nursing, social work, etc...). One must report prior relationships -- go to your supervisor. One must report concerns regarding another staff's behavior -- again, go to your supervisor. Document interactions thoroughly -- if it isn't documented, it DID happen! Remember that a perception of exploitation is all that is needed. Make certain your interactions are part of the treatment -- If not, why? Is your behavior appropriate?



Professional Boundaries Intervention

Please take a few minutes to decide if the following activities are OK between a healthcare worker (you) and a patient, their family, or someone important to them.☺

Please mark an "A" for **Always OK**, an "S" for **Sometimes OK**, and an "N" for **Never OK**.

1. ___ Accept a gift.
2. ___ Give a gift.
3. ___ Give home address/phone number.
4. ___ Give someone else's address/phone number.
5. ___ Go to a meal/break.
6. ___ Meet after work for a movie.
7. ___ Give a ride to the airport.
8. ___ Send a greeting card/letter.
9. ___ Discuss a co-worker's behavior.
10. ___ Share own medical/surgical experiences.
11. ___ Provide overnight housing.
12. ___ Attend their wedding/graduation/funeral.
13. ___ Visit after working hours.
14. ___ Recommend a physician.
15. ___ Stop at their home after patient dies.
16. ___ Borrow or loan money or belongings.
17. ___ Discuss fight with spouse/friend.
18. ___ Pick up fast food.
19. ___ Baby-sit after work.
20. ___ Offer solutions to personal problems.

Each organization has a written policy regarding boundaries. Obtain a copy of the policy at your organization and become familiar with it. An organization should provide a climate for open discussion of boundary issues and provide staff education as needed.

☺ *All of the above activities are never okay.*

Conclusion

Boundary issues are everywhere, and, because of the vulnerable nature of the population with whom we work, we are all at risk of committing transgressions. An awareness of our own boundaries and constant evaluation of our interactions with patients provides an opportunity to heed warning signs and take the necessary steps to maintain appropriate professional boundaries.

Applying What You've Learned...

We recommend that you do one or more of the following activities to apply what you have learned in this section:

1. Discuss patient situations where boundaries have become an issue.
2. Discuss what to do and who to contact in the event of questions related to boundaries.
3. Review institutional policies and procedures regarding patient-staff boundaries.

“Effective treatment boundaries do not create walls that separate...they define a fluctuating, reasonably neutral, safe space that enables the dynamic, psychological interactions to unfold.” (Gutheil, 2002)

CONFIDENTIALITY IN MENTAL HEALTH CARE

Introduction

Privacy and confidentiality are issues that many health care patients have questions and concerns about. In the area of mental health/psychiatry, **patients** may have even greater questions and concerns. The stigma of mental illness and the reluctance to talk openly about mental health issues are often superimposed upon privacy and confidentiality issues in mental health/psychiatry. A common question a mental health/psychiatry patient has is, “Will (name) find out that I have a mental health problem?” If we put ourselves in the place of one of our mental health patients, it is sometimes easier to understand the privacy and confidentiality concerns they have.

There are laws, professional ethical standards, and institutional policies that offer mental health staff guidance in managing privacy and confidentiality issues. Some issues are quite complex; you may need guidance to find your way to the correct decision in the clinical setting. As staff, we need to maintain privacy and confidentiality because of legal, ethical, and professional standards. The patients’ reasons are often very personal. We are obligated as staff to maintain patient privacy and confidentiality. **This obligation or burden always resides in the staff to provide privacy and confidentiality for the patient. Staff need to be strong advocates for the patients in this area.** This section will introduce you to the decision making process for privacy and confidentiality in mental health.

Case Study

Mary is a 46-year-old woman who was admitted to an inpatient mental health unit with symptoms of depression. Mary’s assigned psychiatrist and the nurse assigned to her today ask if they could meet with her. They sit down at a table in the patient lounge area where Mary is sitting. As the staff initiates the conversation, it becomes apparent that Mary is guarded about what she is willing to share and is looking around the lounge frequently, observing other patients and staff in the area. Finally, Mary states she prefers to discuss things where no one else is around. They move to a room where they can’t be heard or observed by others and resume the meeting.

The psychiatrist asks Mary if she has been hospitalized on a mental health unit before and Mary replies, “yes, at another hospital.” The psychiatrist asks if Mary would give permission to obtain those records and Mary consents. While discussing how things have been going prior to admission, the nurse asks if there was a person Mary was close to and could be a contact person for the staff. Mary replies, “I’m not close to anyone except my ex-husband and I don’t want anyone to know I’m in the hospital, not even him.” The meeting is concluded and the staff leave Mary, offering to be available to answer questions or provide assistance in the future.

What is privacy? What is confidentiality?

Privacy and confidentiality are often used interchangeably by health care providers; it may be helpful to define these terms. One author describes **privacy** as “the right to avoid intrusion by an unauthorized third party.” This same author defines **confidentiality** as the “informational arm of privacy.” Most HCPs who are experts in this area, as well as the clinical staff who work in mental health, see privacy and confidentiality as related, but also different.

Using the case study to illustrate the difference; when Mary asked if the interview could be moved to a place by themselves—she was asking for **privacy**. She was requesting to avoid intrusion (being overheard) by an unauthorized third party (other patients, staff, or visitors). Actually, in this case, the staff are in error. The burden of providing privacy is always on the staff, not the patient. The staff should be proactive and advocate for patient privacy.

An example of **confidentiality** is Mary’s request that the staff not contact or inform others that she is in the hospital (except for hospital she had been in previously). This is

an example of the informational arm of privacy, confidentiality. This is information about the patient; verbal, medical record, etc.

Privacy and confidentiality are protections provided by law, professional standards, and institutional policies for all health care consumers. Mental health patients have very good reasons for wanting to safeguard their mental health issues. Staff working in mental health deal with privacy and confidentiality daily. It's important that you know how to deal with these issues and who you can call upon for a resource, because a failure to make the correct decision can have serious consequences for staff and patient. Patient personal relationships, career or employment, and school can all be adversely affected due to an inappropriate disclosure. Institutions and staff have been sued due to mistakes in this area.

Guidelines for Confidentiality

A few rules of thumb:

1. If in doubt—consult!
2. If in doubt—don't give it out! (It's better to postpone release of information until the correct answer is found—except in an emergency situation.)

Institutional Guidelines

Most health care organizations have policies about providing privacy and confidentiality for their patients and how to handle releases of health care information requested by others and/or requested by the organization. Most of these policies parallel the laws and regulations in these areas, but may have some differences due to certain characteristics of the organization (private vs. governmental, inpatient vs. outpatient; treating children vs. adults, legal status of the patient, what kind of programs or funding the organization has, etc...). Please refer to your own organization policies in this area for guidance in making the correct decision about privacy/confidentiality.

Almost all of the above laws, professional standards, and institutional policies apply to all health care patients, but for mental health patients there may be additional privacy and confidentiality concerns. Whether it's in an inpatient, outpatient, or another community setting, these issues are often on patients' minds, but it still the staffs' responsibility to advocate for the patient no matter what the clinical setting is.

Laws, Regulations, and Court Cases

Federal and state laws, government regulations, and court decisions all have contributed to efforts to provide privacy and confidentiality for health care patients. Most people agree that patients have a right to these protections, but many are not aware that this is not an absolute right (some exceptions will be discussed later). These private, individual rights sometimes compete or conflict with rights some individuals or organizations have to patient medical records and information.

Federal Laws

Two Federal laws called the Federal Privacy Act and The Freedom of Information Act address privacy or confidentiality issues for medical providers in federally operated programs (like the V.A. hospitals). These laws generally do not affect non-federally operated programs (like HCMC or private organizations).



- The **Federal Privacy Act** protects against unauthorized disclosure of medical records.
- The **Federal Freedom of Information Act** speaks to the public's right to certain information from the Federal government or Federal Programs. It also spells out what cannot be disclosed to the public.

HIPPA

The Health Insurance Portability and Accountability Act (HIPPA) of 1996 became effective in April of 2001. This law was initiated by the Health Care industry to institute national standards to simplify 3 areas related to patient information:

1. To provide efficiency and effectiveness by standardizing the Electronic Data Interchange (EDI) of certain administrative and financial transactions.
2. To protect the privacy of transmitted information
3. To protect the security of transmitted information.

Protection of patient privacy and confidentiality becomes even more important as technology becomes electronic, such as the electronic medical record. Society also has changing expectations regarding information access, confidentiality, and disclosure. New technology creates new risks and concerns regarding unauthorized or inappropriate access.

Laws Related to Alcohol and Drug Treatment



There are federal laws and regulations in the area of alcohol and drug treatment dealing with confidentiality of these records. Most programs treating alcohol or drug abuse patients that receive federal funds (including federal revenue sharing funds) are covered by these regulations. These laws spell out the process for release of information and even requires the medical provider to resist subpoena of this information. Many mental health patients have co-existing chemical abuse issues and should generally be considered covered by these regulations. They extend almost absolute confidentiality.

Minnesota Laws

In Minnesota there are laws that safeguard patient rights to privacy and confidentiality. One law is the **Minnesota Government Data Practices Act**. This act addresses privacy and accessibility of the medical record for state and local government agencies only (like HCMC), but does not apply to private agencies. This law is designed to protect patients from unauthorized disclosures. It also specifies who has a right to access the medical record and information and guarantees that the patient can control this access to a point. That point is the subject of the other part of the Minnesota Government Data Practices Act—the “**Tennessee Warning**.”

The “**Tennessee Warning**” is the communication of patient rights when a third party requests private or confidential information (i.e., another facility) about the patient. It’s a communication to the patient of what can happen to the information without the patient’s consent. It must state:

1. The purpose and intended use of information.
2. Whether the patient has a right to refuse or must provide information to get service.
3. Any known consequences of supplying or failing to supply this information.
4. The identity of other individuals or agencies that are authorized by law to receive this information (even against the patient’s wishes)—or situations in which the provider is mandated to release, such as child abuse reporting.

Another state law, the **Minnesota Insurance Fair Information Reporting Act** specifies what information and how it can be used by health insurance companies when they need to access patient records.

Access to Confidential Information

Health care organizations must inform patients of these rights. The agencies often require the patient to sign a form saying they have been informed. Agencies may also specify who has a mandated right (see the Tennessee warning above) to access patient information. Some individuals and agencies that have this mandated right are:

- Accrediting agencies (like Joint Commission on Accreditation of Health Care Organizations)
- Worker’s Compensation
- Office of Health Facilities Complaints
- Pre-Petition Screening (the Minnesota Commitment Act concerning commitment)
- Third party payors if health insurance is identified
- A potential victim of a patient, communicable/infectious disease agencies
- Child or vulnerable adult investigators
- As designated by a court order
- Coroner/medical examiner
- Representatives from various State Boards (i.e., medicine, nursing)
- Emergency patient care
- The facility attorney
- Representatives investigating suspicious wounds/burns

All of the types of individuals listed previously assumes that the individuals representing these agencies or investigating these issues are conducting official business, and not looking up information on a family member, friend, neighbor, because the patient record happens to be close and available. This, of course, would be an unauthorized access and individuals have been fired and/or sued and the agency they represent sued as well, for these kinds of breaches of confidentiality.

The issue of who has a right to the patient information and who does not; whom the patient can restrict or not restrict from obtaining this data can be a very sticky one. Most agencies have a designated department (such as Health Information Services) that deals with requests for releases of information regularly. They are the experts when sticky situations come up and are excellent resources.

The treatment team asked Mary if records from another hospital could be obtained. She consented, and the usual procedure is that Mary signs a release of health care information form, and then the signed form is sent to the other facility to acquire the requested information.

Release of Information

This authorization for release of health information should include in the request:

1. patient identification
2. provider name
3. who information is being disclosed to
4. purpose of disclosure
5. type of data requested
6. date signed
7. how long this authorization is valid
8. patient signature
9. a statement that the authorization may be revoked.



Minnesota State law says this authorization is good for a maximum of one year, but the agency can specify a shorter period of time. Authorizations should not predate the treatment. Also, generally, releases for continuing care (such as outpatient, nursing home, or another facility) are okay as long as it was related to the current episode of illness or treatment.

Mary could have refused to sign the release of information if the request was for a hospitalization not related directly to the current one. If Mary did refuse, the treatment teams' hands would be tied as far as obtaining these records.

Restricting Access to Confidential Information

Mary is also within her rights to prevent information being given to family members, friends, people at work or school, or other individuals or organizations, as she chose to do in the case study. Except for mandated releases like legal guardians and others provided by law, she may believe or imagine that it would adversely affect her personal relationships or her employment, or she may be too embarrassed to tell others about her mental health problem. Patients have full discretion in this area and can change their minds at any time. They are not obligated to give staff reasons for their decision. They can be selective in who they give information to, but they should be informed that the organization has no control over inappropriate disclosures to others by the selected individual.

After a week in the hospital, Mary changes her mind (she has a right to do this) about informing friends and family that she is in the hospital. She starts to receive visitors and phone calls from others. She is surprised by the response she receives from these people and appreciates the support, but she says, "I still don't want my ex-husband to visit or call—he's such a jerk!" Staff will attempt to comply with this, as best they can,

but staff tell Mary that they have no control over friends and family informing the ex-husband about Mary.

Hospital Directory Information

Mary could choose to be on a full or strict confidential status and directory assistance would give out no information. Many organizations have a mechanism for this.

The Patient Bill of Rights

Another state law, called the Patient Bill of Rights, addresses privacy and confidentiality issues as well. This Bill of Rights has many provisions unrelated to privacy and confidentiality, but the provisions of concern to us are:

1. *Patients have a right to complete and current information about their condition and treatment in understandable language.* This information can be withheld from a patient if it is medically inadvisable to provide this information (including mental health/psychiatric reasons), but the medical team should state this in advance of the request by the patient.
2. *Patients have a right to respectfulness and privacy during examination and treatment.* In the case study, Mary requested to have a private discussion with the treatment team members; this was granted. Unfortunately, staff often forget about these privacy concerns of the patient, and patients may not be assertive enough to advocate for themselves.
3. *Patients have a right to confidentiality of their personal and medical records.* Patients can/may approve or refuse releases with the exceptions as discussed above.

Exceptions to Confidentiality Rules

There are a number of exceptions or cases where confidentiality needs to be broken to provide care or protection to the patient or others. Examples of these exceptions are:

- Medical emergencies
- Patient incompetence or if the patient has a guardian
- Involuntary commitments
- If the patient is a minor

In some cases staff are obligated by law to report certain situations to the appropriate authorities. These situations can include abuse, neglect, or maltreatment of a child or vulnerable adult; and communicable diseases (HIV).

If in the course of the hospitalization Mary had a cardiac arrest and required emergency treatment, confidentiality could be breached to contact family, other doctors or facilities to obtain vital medical information. It could be justified by two of the above exceptions; it's a medical emergency and she would be temporarily incompetent to make her own decisions.

There is another exception based on a court case in California called the Tarasoff ruling. This says that staff is required to inform third parties, or potential victims if a patient makes a threat against someone. This is also called the Duty to Warn. (See Legal Aspects in Module I).

When You Know Your Patient

It's a small world; and there may come a time when you find yourself in the same treatment setting as a family member, friend, neighbor, or a distant acquaintance. How do you handle this? If you were Mary and this happened to you, would you have the courage to speak up? As staff, we are obligated to speak up and address this issue directly, but sensitively. Many organizations have formal or informal ways of dealing with this situation; but it is often the best policy to not have that staff person work with that patient directly. We need to advocate for the patient, because often mental health patients are not able to advocate for themselves.

Institutional Guidelines

This leads us to another set of guidelines in this area provided by institutional or organizational policy or standards. Most health care organizations have policies about providing privacy and confidentiality for their patients and how to handle releases of health care information requested by others and/or requested by the organization. Most of these policies parallel the laws and regulations in these areas, but may have some differences due to certain characteristics of the organization; private vs. governmental, inpatient vs. outpatient, treating children vs. adults, legal status of the patient, what kind of programs or funding the organization has. Please refer to your own organization policies in this area for guidance in making the correct decision about privacy/confidentiality.

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Confidentiality in the Inpatient Unit

In the inpatient setting, privacy and confidentiality come up regularly for patients and for staff.

Mary comes to the nursing station and says that she would like to use a phone that provides more privacy than the one in the patient lounge. The Minnesota Patient Bill of Rights states that she has a right to this. This also includes the right to meet privately with anyone of Mary's choice. Regarding the phone situation, Mary was provided a room and phone where she could converse in private.

Many facilities require the patient to sign an agreement that includes information about privacy and confidentiality when they first have the professional contact. This agreement may inform them of their rights in this area as a patient; it may also be used as consent for disclosing certain information, such as the information needed for billing purposes, continuing care, and possibly other reasons.

Consent

In the area of mental health, if a patient is cognitively impaired and their competence to consent at the time is questioned, it may be necessary to go back to this patient later when they have improved to receive a more valid consent. If the patient's competence is questioned and they haven't been legally judged so, it should be documented as such, and the next of kin or a proxy could give consent. If the patient is legally judged incompetent, then the designated guardian can act for them. This issue can come up occasionally when mental health patients require surgery or procedures due to a physical condition. Of course, in these situations, confidentiality exceptions would come into play.

In mental health programs, patients have all the rights of other health care patients, and possibly additional considerations and issues. Patients in mental health may have heightened privacy and confidentiality concerns due to the social stigma that is still associated with mental

health problems. As staff, we need to be sensitive to these patient concerns and advocate for their privacy and confidentiality.

Privacy About Mental Health Information

Patients often wish to avoid having other patients, or even staff not involved in their direct care, overhear or having access to their mental health information. Phone conversations or patient interviews by the treatment team can easily be overheard by others at times. Patients often prefer that meetings with visitors be held with more privacy. In the case study, if Mary requests a private visit with family members, the staff and facility should do the best to accommodate this. Patient care areas should be designed so that patient interviews, phone conversation, and visits by others facilitate privacy.

Confidentiality and Staff Conversations



Another area of confidentiality that staff are not careful enough about is conversations among themselves. Whether it's behind the staff desk, in the lunch/break area, on the elevator, or in the hallways—staff conversations are often overheard by people who should not. This includes both patients, families, and other staff members. Always check the immediate area before discussing patient information. It's a small world and for all you know, a patient's family member may be lunching right next to you!

Confidentiality in the Computer Age

With the information age and the era of media and computer systems here, patient information is potentially accessible many different ways. Computer screens, medical record copies (like lab and other test results), and charts for that matter, should not be viewable and accessible to patients. Even authorized viewing of the medical record by the patient should be under the supervision of a staff person. Patients have been known to destroy the medical record when they have had inappropriate access. Even the disposal of the paper medical information should be out of reach of patients.



Let's say Mary asks to view the medical record because she's concerned about what a staff person wrote about her. Since the psychiatrist didn't

write an objection to this in advance, Mary was allowed to review the charting accompanied by a staff person. As it turned out, Mary didn't find anything objectionable, but did ask the staff person to clarify some information she noted.

Group Therapy

Many therapies in mental health involve groups. Group therapy can bring up other privacy and confidentiality issues. Usually the group's professional leaders set the norms (or rules) for the group participants and inform them of these norms. Usually the norms address issues of confidentiality. A common one is that all participants must not share things that are said and done in groups with anyone outside of the group. There may also be norms about not discussing others or socializing with other group members outside of group time. The professional staff may share group information for clinical purposes. These are the basic group norms involving confidentiality.

Teaching Hospitals

Many clinical settings are also teaching facilities or settings. Training students of every discipline may include patient information disclosures. Students, interns, residents, etc. are all usually expected to comply with the same standards regarding privacy and confidentiality as the staff. They may require training in this area. Audio and video taping, transcribing information and other teaching methods may require patient permission in advance to allow this to happen.

The Famous or Infamous Patient

A facility may have a patient that is well known to the public or may have committed a crime, and the public or the media is seeking information. The facility must keep patient matters confidential unless the patient grants permission. Many facilities have policies on how to manage these situations. Some facilities include patients in their publicity literature and photographs. It is absolutely essential to get patient permission, in advance, when doing this type of thing.

When You Get Information Without the Patients' Consent

In mental health, we encourage patients to share appropriate information to allow us to provide good quality care. While many patients share many details of their life, it is within their right to refuse to provide information verbally or by other means. This often puts staff in the uncomfortable position of trying to provide

care without the patient cooperation and information desired.

Mary has been assigned to the same nurse, Nancy, for a number of days in a row. Mary enjoys having Nancy as her nurse and begins to share and trust her with a lot of personal information. Mary tells Nancy about her ex-husband physically abusing her in the past. Mary is embarrassed about this and asks Nancy to not tell anyone else—even her psychiatrist. Nancy tells Mary that professionally and ethically she cannot keep this confidential and Mary is upset about this at first, but after Nancy explains it more, Mary agrees that it is a good idea to tell the psychiatrist.

In the case study, if Mary hadn't volunteered the information that her ex-husband had abused her in the past, the staff may never have found out and considered this information when developing a care plan. Staff may have received this information another way, with or without Mary's knowledge or consent. It may be through other medical records (old or requested ones), unsolicited information from family, friends, or other providers. If Mary allows contact with outside individuals, they may volunteer information that is not necessarily requested by the treatment team, but is initiated by these outside individuals. If it is information obtained from another facility by a signed release of information (by Mary), the facility that Mary is currently in would not be allowed to redisclose this information to a third facility without Mary's permission. Redisclosure without permission is not okay.

Research and Confidentiality

The unit that Mary is on is currently doing a research study on depression. The staff approaches Mary about being part of the study. They inform her of the objectives and the particulars of the study and assure her that her identity will remain protected. Despite this, Mary says she is not interested and the staff do not include her in the study.

In 1997, Minnesota passed a law saying that a patient needs to be informed that outside researchers (outside the facility) may use their medical record for research. It also says patients have a right to say no. Often this is part of the consent talked about above. The researcher cannot contact the patient directly until he consents in some types of research. Some research is done by record review only. Patients also have the right to say no to this type of research.

Confidentiality in the Health Care Team

All health professional groups have professional, ethical standards when it comes to the issue of patient privacy and confidentiality. So even if there weren't all these laws and regulations the professional staff (doctors, nurses, social workers, occupational therapists, recreational therapists, etc.) would still be obligated to safeguard patient privacy and confidentiality.

Most organizations also have non-professional staff (support staff, HUCs, mental health workers, psychiatric assistants, etc.); these staff don't necessarily have these same professional standards. Non-professional staff generally work under the supervision of the professional staff; the professional staff should make sure their supervised staff are complying with privacy and confidentiality standards.

Mary can trust that if a HUC on the unit where she is hospitalized happens to be a neighbor, the HUC will not inform anyone outside the hospital about Mary and will not view Mary's medical records unless it is required during the conduct of her job.

As part of the health care team, staff cannot keep clinical information private upon patient request and in fact, are required by law to inform the appropriate authorities when certain information comes to light (see earlier in program).

The patient record is the property of the facility, but patients have a right to review the medical record (unless it is contraindicated for medical or psychiatric reasons) and to formally object to information they don't agree with there. Many facilities have a procedure to allow patients to reply to information in the medical record.

Patients may be denied access to their own chart by staff, on the determination that seeing the chart:

- Would be detrimental to physical or mental health
- Is likely to cause the patient to inflict harm on self or others



Confidentiality and Children

For those working with children as patients, there are additional considerations. Generally for minors, the parents can authorize releases of information and they have a right to the child's health information. In the

case where the parents are divorced, both parents have these rights unless a court decision has decided otherwise. In the case of an emancipated minor, the minor has the control in these matters. There may be exceptions in this area as well as other areas we have discussed, so it is often advisable to consult the information management department or attorney for the facility.

Summary

We hope that this program will assist you in making the right decisions regarding patient privacy and confidentiality in the future. As you can see, it is a very complex issue and to serve the patient well we need to be mindful of the possible concerns a mental health patient like Mary may have. Remember the three rules of thumb for privacy and confidentiality:

1. If in doubt—consult!
2. If in doubt—don't give it out! (Postpone)
3. Document your decision making process

Applying What You've Learned...

We recommend that you do one or more of the following activities to apply what you have learned in this section:

1. Discuss patient situations where confidentiality has become an issue.
2. Practice identifying situations in which confidentiality may be breached.
3. Review institutional policies regarding confidentiality.

THERAPEUTIC MILIEU

What is a "Therapeutic Milieu?"

The American Heritage Dictionary defines **Therapeutic** as "having healing or curative powers; gradually or methodically improve." It defines **Milieu** as "an environment or surroundings." Maslow suggests that the basic physical needs must be met before a person can work toward resolving their physiological needs. The elements which enhance a healing environment include:

- physical and psychological safety
- trusting relationships with staff members
- a framework on which to educate patients and assess needs and progress.

The Elements of a Therapeutic Milieu

Physical Safety

Safety is of the utmost importance in a therapeutic milieu. It is primarily the responsibility of the nurse to maintain a safe and therapeutic environment, protected from yelling, cussing, arguing, violence, "dirty" stories, inappropriate stories, or touching and intrusive behavior.



To facilitate this safety, all patients are checked in immediately on admission. Contraband, sharp objects, plastic bags, lighters, razors, and glass objects are removed from easy accessibility. Visitors coming into the unit are questioned as to what they bring into the area. Police deputies who serve court papers, transport patients to court or state facilities are not allowed to bring their guns onto the unit. Most units have Gun Boxes where weapons are locked up. An alternate method to deal with this situation is to instruct staff to escort the patient off the unit to the deputies. Finally, only educational and "PG-rated" movies are allowed for viewing by patients.



Trust

Trust in staff members evolves as patients witness interactions with others in the communal areas. Mealtime is often the largest gathering of patients. When patients witness helpful and respectful behaviors by the staff toward their peers, they feel nurtured and safe.



Patients must know that trained staff will intervene if another patient loses control. When patients witness staff setting limits in a swift and non-judgmental manner (one that discourages a behavior without disapproval of the person), they feel protected and accepted.

Confidentiality is also a major characteristic of a therapeutic milieu. Patients must know that the information that is shared with the staff will be held in strict confidence and will not be discussed outside of team meetings or nursing reports. The staff may confirm the presence of a patient on the unit to a telephone caller, but may not share any further information unless the patient gives written consent (Hennepin County Medical Center and Regions Hospital only). Last names are not shared by the staff with other patients; only the first name and last initial may be used.

Finally, celebrating birthdays and holidays is another way to build trust and self-esteem for the patients.

Structure

Structure is vital for a therapeutic environment. The nursing education groups provide new insights for patients. Occupational therapy groups assist the treatment team to evaluate the cognitive abilities, social skills, and memory of the patient. Frustration tolerance and socialization skills are also monitored during therapy groups. Informal social times and visiting hours shed light on a patient's personality and personal boundaries. A balance of relaxation and structure is beneficial to psychiatry inpatients. Patients with a higher level of functioning seem to benefit from a higher level of structure.

Aesthetics also play a role in therapeutic milieu. When the décor is pleasant and comfortable, the environment can be perceived as welcoming and relaxed. When the décor is institutional or sterile the environment can be perceived as frightening or "prison-like." Calming colors, a well-lit, cheerful space, and comfortable furniture, augment the healing environment. Games and puzzles in good repair, and current reading material are indicators to the patient and family that the hospital values them.

Patients also need their privacy – semi-private rooms are optimal. A private space for telephone conversations as well as visitors improves a patient's trust level of their hospital experience. Patients also need space. There should be adequate space for the patient to pace around the unit and places for the patient to be alone.

The Role of Staff Members in the Therapeutic Milieu



Each and every member of the treatment team is important to the psychiatry patient's progress. Each member is responsible for a safe, respectful, and healing environment. Each staff member brings his/her own personality and attitude to the unit with them; the staff member must also take responsibility for that attitude. Keep in mind that silence and facial expressions are also communicated to patients.

(In alphabetical order)

The **Health Unit Coordinator (medical clerk)** processes helps to maintain the patient record. This person screens telephone calls, monitors the electric door locks, and takes responsibility for the FAX machine – sending and receiving faxes; delivering information to appropriate staff member. The medical clerk on inpatient units has

frequent patient contact and has the role of notifying nursing staff when patient issues come up.

The **Housekeeper** provides and maintains a clean and safe environment and reports any contraband found on the unit. They prepare the room to appear welcoming and comfortable for each new admission.

The **Nursing Assistant (NA)**, under the supervision of the RN, is responsible to help maintain a safe and secure milieu for the patients. The NA helps facilitate unit meetings and encourages patient participation in structured groups and goal setting on the inpatient unit. The Psychiatric Nursing Assistant provides back-up and support for the RN during limit setting and behavioral crisis. Additionally, the NA often observes incidents that are vital to communicate to the RN and treatment team to ensure safe, quality care. The **Mental Health Worker (MHW)** at Hennepin County Medical Center assists in managing the milieu and is assigned to specific patients.

The **Occupational Therapist (OT)** assists the patient by structuring the patients time with groups and tests which assess and evaluate problem solving abilities, social skills, cognitive tracking and frustration tolerance.

The **Psychiatrist (MD)** leads the treatment team in developing a treatment plan which is individualized for the needs and problems of each patient. The psychiatrist completes a medical evaluation, history and physical, and mental status examination. S/he initiates orders which direct the team to evaluate the care for the patient. The care plan is re-evaluated daily.

The **Registered Nurse (RN)** assesses and reports the needs of the patient to the team from the moment of admission into the unit. The RN implements MD orders, which include medication administration and evaluation of medication effect, and documents the progress of the patient. The RN builds a trusting and therapeutic relationship with the patient and family through which the RN can educate them about legal rights, the illness, and treatment modalities. The RN manages the unit in relation to whom or what comes and goes and the level of noise. The RN also coordinates with team members and manages the therapeutic milieu.

The **Social Worker (SW)** assists the patient in preparing with discharge from the hospital. The SW sets up intake interviews with group homes, mediates with families, and has a vast knowledge of community support systems and qualifications of facilities, such as Rule 36¹ facilities, group homes, adult foster care, chemical dependency

¹ Rule 36 refers to the licensing of residential facilities for adults with mental illness. It establishes standards for mental health programs providing residential treatment and rehabilitation services to adults with mental illness on a 24-hour per day basis.

treatment programs (inpatient and outpatient), and Rule 25² evaluations. The SW is responsible for monitoring the course of petitions that are filed when a patient is in the process of civil commitment.

The **Student** (Medical, Nursing, Occupational therapy, Social Work or undergraduate Behavioral Health Program) becomes part of the treatment team developing their skills (see each professional role).

The **Therapeutic Recreation (TR)** staff provide on-unit and off-unit therapy groups that provide structure, leisure activities, relaxation, exercise, and opportunities to engage with other patients (Hennepin County Medical Center only).

The **Volunteer** provides a positive presence in the therapeutic milieu. The volunteers' activities help to enhance and create a healing environment for the patients.

Conclusion

Creating and maintaining a therapeutic milieu for psychiatric patients can be a challenge. The patient with a psychiatric disorder can, however, do their best in an environment in which there is safety, trust, and structure. The role of the mental health staff is vital in creating and maintaining the therapeutic milieu.

Applying What You've Learned...

We recommend that you do one or all of the following activities to apply what you have learned in this section:

1. Discuss the elements in your environment that add to or detract from the therapeutic milieu.
2. Observe other staff members in their roles in maintaining the therapeutic environment.
3. Review the Patient's Bill of Rights and policies and procedures related to the "least restrictive" environment principle.

THERAPEUTIC RELATIONSHIPS AND COMMUNICATION

Introduction

The actual work of the "helping professional" takes place within a therapeutic relationship. This evolving

² Rule 25 refers to the formal evaluation of a patient for chemical dependency. If the patient is found to be chemically dependent, and is amenable to treatment, the state/county will pay for the treatment.

relationship is interactive, unique, and complex. Both the health care provider (HCP) and the patient bring their unique selves and individual ways of reacting emotionally to the relationship to communicate in ways that affect each other. This relationship is a goal-directed process through communication and relationship building, specially fitted to the health needs of the patient. This process involves the exploring of ideas, feelings, and attitudes related to the desired health care outcomes for the patient.

The following section will begin by exploring the characteristics and qualities of the therapeutic relationship, with further focus on the necessary elements of communication needed in order for a successful relationship to occur.

The Therapeutic Relationship

The Nature of the Health Professional/Patient Relationship

The goals of all therapeutic relationships are to promote health recovery, maximize the patient's well-being, and support self-care actions of the patient. The patient may be on one extreme of the illness/wellness continuum and require total physical care, or may be on the other extreme and require health education and emotional support.

Consider the therapeutic relationship as a foundation for all biophysical, psychosocial, and cognitive treatments. The treatment process can fail if a patient doesn't understand it, or if the patient is indecisive, anxious, reluctant, or opposed to participating fully with the plan. The development of a therapeutic relationship often enables patients to perceive and react to illness in a more productive way. The therapeutic relationship can directly or indirectly affect the quality of the patient's life.

Structuring a therapeutic relationship doesn't just happen. It requires a considerable amount of time, thought, sensitivity, and energy. A helping professional can't enter into this process passively; it truly involves a conscious commitment. Some helping relationships extend over weeks and months, while others take place in the span of an eight hour shift.

Relationships: Therapeutic vs. Social

A therapeutic relationship and social relationship have several elements in common, but also have unique differences that set them apart. It is very important to be able to differentiate what is truly a therapeutic relationship and what constitutes a social one.

How are they alike?

Both types of relationships involve personal contact and a discovery of the other person. They both involve a give and take in the discussion, as well as an opening of the self to the other person. Most enter both types of relationships to seek an understanding and acceptance for their own uniqueness as a person.

How are they different?

The key differences in a therapeutic relationship are that all behavior and actions are purposeful, planned, guided, and evaluated by the helping professional. These actions are all directed in helping the patient meet identified treatment goals.

The HCP takes primary responsibility for maintaining the boundaries and guiding the relationship. These boundaries are marked by:

- the purpose
- person-centered communication
- stages of development
- health related issues that are being addressed

Over-involvement

A helping professional continually walks a fine line between a compassionate, but not overly close, relationship between themselves and their patients. The therapeutic relationship loses its value if the HCP is over-involved in the patient's life. Countertransference reactions may play a large role in over-involvement. For example, the HCP may feel a strong emotional commitment to the patient because the patient reminds the HCP of someone in the HCP's past.

Signs that you may be over-involved include:

- giving extra attention to certain patients
- visiting patients during off-hours
- not promoting capable patients to do things for themselves (you do it instead)
- strong emotional feelings about the way other members of the health team relate to your patient
- downplaying other providers in regard to your patient

When there are signs of over-involvement, the HCP needs to pull back from the situation and regroup. A respected peer or mentor can also be very useful for the HCP to gain a clearer perspective of the situation.

For more information on Boundaries in Professional Relationships, please read the section "Boundaries" in this program.

Detachment

An HCP's unwillingness or inability to develop a helping relationship can also be problematic for patients in meeting their health goals. Reasons for this include:

- The HCP may lack experience and is therefore hesitant to become involved.
- Patient situations may emotionally drain the professional; for example, patients who fail to progress, or patients whose behaviors conflict with the HCP's value systems.
- The HCP may be having difficulty coping with his own personal problems that cause him to have little emotional energy or strength to actively participate in the relationship.

The Therapeutic Use of Self in the Health Professional/Patient Relationship

Carl Rogers (1961) is a well-known theorist on helping relationships. He states that the **self** is the key helping tool in a therapeutic relationship. Rogers states that the first step in developing the therapeutic relationship is to do a little self-analysis.

Ask yourself the following questions:

1. Am I perceived by the patient as trustworthy, dependable?
2. Can I let myself experience attitudes of warmth, caring, liking, interest and respect?
3. Am I a strong enough person to be separate from the patient?
4. Am I secure enough to allow the patient to be separate?
5. Can I enter into his/her world of feelings and personal meaning and see these as she does?
6. Can I accept the patient as he is and communicate this, or only receive him conditionally?
7. Can I act with sensitivity so that my behavior will not be perceived as threatening or evaluating?
8. Can I see this patient as one who is in the process of becoming, not just be her past or my past?
9. Can I communicate clearly?

Effective health providers have self-awareness. They are able to examine their personal feelings, actions, and responses, and develop an understanding and acceptance of their own selves in order to acknowledge and accept a patient's unique self.

Campbell (1980) further describes his theory of self-awareness, consisting of four elements:

1. the **psychological component** includes being sensitive to feelings (having the knowledge of your emotions, motivations, self-concept, and personality)
2. the **physical component** is having the knowledge of your body, as well as of bodily sensations, body image, and your physical body potential.
3. the **environmental component** includes having a relationship with others and nature.
4. the **philosophical component** is having the understanding that life has meaning and we are responsible to the world and have ethics regarding our behavior.

The following characteristics are all components of using your "self" in the therapeutic relationship:

Values

Developing an understanding of your values is another component of understanding your self. Values are a person's beliefs about others, life events, and situations that are formed as a result of experiences in the world. They are influenced by our culture, family and friends, education, work, and leisure activities. Values are what guide our behavior. It is our road map in life.

Value clarification involves assessing and exploring what your values are, as well as what priority they hold in your decision making process. The health professional should be able to answer the question, "What is important to me? What guides my actions?"

The temptation to use patients for the pursuit of personal satisfaction or security should be avoided. Being aware of your own values assists in keeping you honest and helps avoid this use of patients to meet your personal needs. By being aware of your own value systems, you can identify patient situations that may be in conflict with your value system. This identification can then assist you in maintaining objectivity against the temptation to project your values onto your patients.

Openness to your own feelings

Developing an awareness of self and your values requires becoming conscious to your own true feelings. By allowing your emotional experience to be felt, you can accept your feelings and behavior that goes with them. You may also give up behaviors that aren't consistent with your values, that do not meet your needs or that are dictated by others. Behavior that is based on true feelings is not only satisfying, affecting your self-esteem in a positive way, but also promotes trust in yourself. You can then recognize that perception is personal and subjective, allowing you to do a better job at remaining nonjudgmental and objective in the therapeutic situation.

Role modeling of healthy behavior

Research has shown that role models have power in molding adaptive (as well as maladaptive) behavior. HCPs in a helping relationship have a strong influence on their patients, and have an obligation to model healthy, growth-producing behavior. This is true even in the context of being seen on the unit/ward by the patient. It doesn't need to be a formal, 1:1 situation. If you have a chaotic, crisis-oriented personal life, it can show in your work with your patients. This can decrease your effectiveness and credibility as a helper.

Altruism

The HCP needs to ask, "Why do I want to help others?" Obviously, an effective helper is one that has an interest in people and a desire to promote positive social and health care change. You also need a certain amount of personal satisfaction and fulfillment from your career in order to continue in the field. The goal of the HCP is to maintain a balance between these two needs. This business involves **caregiving**, not **caretaking**. Helping motives that aren't in balance can be destructive to the patient, the therapeutic relationship, and to the personal welfare of the health professional.

Professional ethics and responsibility

Professional ethics is another component of utilizing the self in the therapeutic relationship. Ethical choices involve risks, accountability, commitment, and justice. You are responsible not only to the patient, but also to your organization and profession.

You need to assume responsibility for your behavior, as well as to know and be accountable for your strengths and limitations. It is your obligation to utilize the expertise

and knowledge of others when assistance or consultation is needed.

Sense of Humor

Using humor effectively in the therapeutic relationship certainly is another way of maximizing the use of “self.” It can be used in establishing the relationship **and** assisting in decreasing stress and tension. It is a way to express emotion, to reinforce one’s self-concept, as well as being effective in facilitating learning. The effective use of humor in the relationship must be assessed on an individual basis, as well as how it relates in the current situation. For example, humor can be inappropriate if it violates the patient’s values or is degrading. It also is inappropriate when it encourages the masking of feelings, enhances maladaptive coping behaviors, or assists the patient in not addressing the difficult situation at hand.

How can you develop your awareness of self?

1. Listen to your self. Allow your emotions and feelings to be experienced. This means to fully explore your personal thoughts, feelings, memories, and impulses. It involves acceptance of your personal needs.
2. Listen to and learn from others. As we listen and are open to feedback, we broaden our own perceptions of ourselves.
3. In your personal relationships, reveal to others important aspects of your self. Allowing people to know you is a way of achieving a healthy personality.

Actively working on increasing your self-awareness is not always easy or pleasant, but it presents a challenge to oneself in learning to accept one’s own limitations or learning to change the behaviors that support them.

Characteristics of Effective Helpers in the Therapeutic Relationship

Certain qualities are necessary to initiate and continue a true therapeutic relationship. These qualities consist of a blending of verbal and nonverbal behaviors with the attitudes and feelings behind communication. These characteristics are listed below.

Genuineness

Genuineness means that the HCP responds sincerely. You should not be thinking or feeling one way and saying

or behaving the opposite. You can’t expect openness and honesty in patients if you lack these qualities. This doesn’t mean you must or should make a complete self-disclosure, but whatever you show must be real, and not just a learned, canned professional response.

Unconditional Positive Regard (Warmth and Respect)

Unconditional positive regard can be described as “caring and valuing in a nonjudgmental fashion, without criticism or reservation.” There is basic respect for the patient. The HCP does not demand that the patient be perfect or change in order to be accepted. The imperfections are accepted along with the mistakes, and a patient’s behavior is viewed as natural, normal, and expected given the circumstances. However, this acceptance also means that the patients’ coping behaviors can change as the patient becomes less threatened and learns more adaptive mechanisms. This respect for the patient is most often not communicated directly in words, but is communicated utilizing a variety of other communication skills (i.e., use of attending skills).

Empathy

Carl Rogers describes empathy as being able to sense the patient’s world **as if** it were your own, but without losing the “**as if**” quality. Empathy means being able to accurately perceive the patient’s feelings and their meanings, and be able to communicate this understanding in both verbal and nonverbal ways. It means being able to put yourself in the patient’s place, but not lose yourself in the emotions. Empathy should not be confused with sympathy, as it is not necessary or desirable for the HCP to “feel” the same emotion as the patient. This could become more of an obstacle in meeting the goals of the relationship, as objectivity may be lost in the process.

The following outlines the findings regarding empathy and illustrates why this is so important in a helping relationship (Stuart, 1998):

- Empathy is related to a positive clinical outcome.
- Empathy is related to self-exploration and self-acceptance.
- Early use of empathy in a relationship predicts later success.
- The use of empathy can be learned from empathetic people.
- More experienced therapists are more likely to be empathic.

- The better self-integrated the therapist, the higher the degree of empathy.

Carkhuff (1969) identifies five levels of empathy, from least to most empathetic...

1. Unaware of the patient's message of feelings (no evidence of active listening or understanding by the helping professional).
2. Superficial acknowledgement of the patient's message, but little of their feelings.
3. Recognition of the patient's message and some of his/her feelings.
4. Acknowledgement of the patient's message and obvious feelings.
5. Full acknowledgement of the patient's hidden messages and feelings.

Empathy can be communicated in verbal and nonverbal ways. Using attending behaviors of maintaining eye contact, open posture, nodding head, smiling, and listening are nonverbal ways of demonstrating empathy. Examples of higher level verbal empathetic responses include:

- What I hear you saying is...
- It sounds to me like...
- You appear...
- I would be upset, too, if...
- If I'm hearing you correctly...
- It must have been very scary...
- It seems to me that...

These responses include statements of clarifying, asking open-ended questions, validating perceptions, and restating the issues as well as statements attempting to analyze the emotions or behavior.

Concreteness

Concreteness can be described as using clear, direct language when discussing the patient's experiences, feelings and behaviors, not abstractions. It involves using specific language that avoids vagueness and ambiguity. Stuart (1998) states that concreteness should vary during the phases of a relationship. In the beginning phase, concreteness should be high, as this is the essential time for formulating goals and the plans to achieve them. During the working phase, it may be at a lower level, which can help facilitate self-exploration in relationships in working on meeting the goals and feelings and

behaviors associated with this. At the termination phase, high levels of concreteness are important, as this is when the patient is engaged in her action plans and their working relationship with the health professional will be ending.

Consider the characteristics of genuineness, unconditional positive regard, empathy, and concreteness as the bridges to the therapeutic relationship and the use of self. They are essential components that facilitate the development of the relationship as well as maintain the effectiveness of the relationship in its working phase.

Phases of the Therapeutic Relationship

Arnold and Boggs (1995) utilize Peplau's work (1952) to describe the phases of the therapeutic relationship. They acknowledge that though each phase is categorized separately, they are not mutually exclusive of each other, but involve overlaps from one phase to another. For purposes of discussion, the phases will be described as separate stages.

Pre-Interaction Phase

Consider this the only period of time where the patient is not actively involved. This is the stage where you explore your own professional goals, and evaluate your personal characteristics, needs, and values that could impact the relationship.

The environmental setting and available resources are evaluated, as well as addressing the circumstances, fact, and conditions that could hinder or facilitate the development of a relationship. Organizing of time so that priorities are set and relationship goals are realistic and achievable is also addressed in this phase.

Orientation Phase

This phase begins with the patient seeking assistance and when contact is made with you, as the health professional. From the very first encounter, you need to convey the expectation that the relationship is one of partnership. This understanding should communicate that the patient has something that is valuable to the relationship, as well as stimulating an atmosphere of hope.

During this phase, the patient asks questions, conveys educational needs, shares expectations and preconceptions of the relationship based on past experience. The patient may also be testing the parameters of the relationship.

Depending on the circumstances, this is the time for the patient's wants and needs to be clearly identified, as well as mutually defined health goals established. The therapeutic contract is developed, with the purpose and time frame of the relationship, goals, and roles in the relationship identified.

Working Phase

Consider this phase the problem-solving phase of the relationship. By this stage, it is hoped that the patient is feeling trust in the relationship and is able to actively work on exploring the issues/feelings/problem areas and be able to focus on discovering and testing possible solutions. Your focus is to facilitate this process by utilizing all of your effective communication and assessment skills, providing information, and facilitating the problem solving process.

Termination

The final phase of the relationship occurs when the work of the active intervention phase is finished. During this phase, the patient is becoming more of an independent person, applying new problem-solving skills, as well as aspiring to new goals. You have focused on assisting with goal setting, teaching preventative measures and self care, as well as utilizing community agencies as needed. Summarizing and evaluating the completed work is necessary in this phase. Concrete plans for follow-up must be established before the relationship is terminated.

Barriers to the Therapeutic Relationship

Transference, countertransference, and boundary violations can all block the progress of the therapeutic relationship. Further information on Boundary Violations is in the "Boundary" section.

Transference

Transference is an unconscious **patient** response of feelings and attitudes toward the HCP that are very similar to the feelings and attitudes the patient experienced with a significant person in their past. These feelings and attitudes (demonstrated by patient behavior) may be triggered by some similarity from the significant other, such as the tone of voice or the manner of the HCP, similar facial features, or the way they walk. The HCP may remind the patient of an authority figure from the past, such as a parent or perhaps a former spouse.

Transference can present problems in the therapeutic relationship. These reactions can be harmful if they remain ignored and not evaluated. A hostile transference may occur, with the patient becoming critical, defiant, or irritable. Another type of transference is a dependent type of transference. Patient dependency behaviors include demonstrating submission, being subordinate, or regarding the health professional as a godlike figure.

These responses can pose challenges in the therapeutic relationship. You must be ready to be exposed to powerful positive and negative feelings from the patient (often with an irrational basis).

Analysis of the transference needs to be focused on the patient's gaining awareness and becoming responsible for his own actions and behavior. Your first role is to listen, then to use clarifying and reflecting statements to help focus on what is really happening. The goal is to not only identify that the behavior is occurring, but explore possible reasons for its occurrence. This will help the patient gain insight into his behavior and to decrease the barriers in the therapeutic relationship.

Countertransference

Countertransference can be described as an inappropriate response by the **health professional**, generated by the qualities of the patient. This response is inappropriate in the degree of intensity of emotion or in the context of the relationship and is not justified by reality. The HCP connects the patient with people from her past. As a result of this connection, the HCP has reactions of intense love or caring, reactions of intense disgust or hostility, or reactions of intense anxiety.

The experienced health professional is constantly aware of the possibility of countertransference. A self-examination throughout the relationship (especially if the patient attacks or criticizes) should be utilized. Stuart (98) identifies the following questions that may be helpful in determining if countertransference is present.

- How do I feel about the patient?
- Do I look forward to seeing him/her?
- Am I afraid, feel nervous, or dread seeing this patient?
- Does the patient make me angry or frustrated, or do I want to punish the patient?
- Do I feel sorry or sympathetic toward the patient?
- Do I try to impress the patient?
- Do I get extreme pleasure out of seeing the patient?

By answering these questions, the HCP should get an idea about where there may be a problem in the relationship. When a potential problem is recognized, the HCP must actively pursue it to discover the source of the problem. Countertransference needs to be recognized so the HCP can consciously exercise control over it. If further assistance is needed, individual or group supervision can be helpful in addressing this issue.

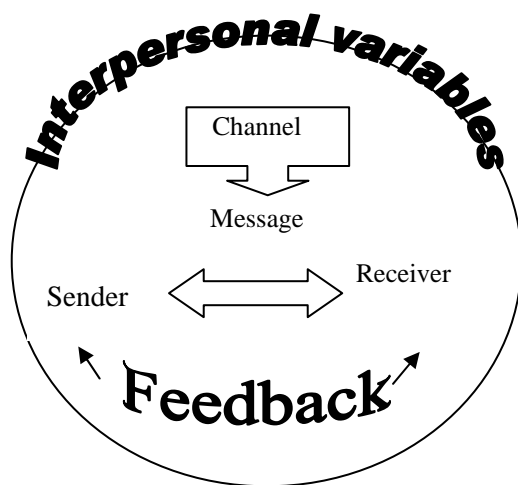
Communication

General Principles of Communication

Effective interpersonal communication is essential in the development and maintenance of a therapeutic relationship. Basic principles of general interpersonal communication will first be reviewed before specific skills are described.

All communication involves five elements: a sender, a message, a receiver, feedback, and content.

Communication is a complimentary process in which all participants are actively engaged. The process is a lot like playing ball. To play it well, the players must be active and pay attention to all aspects of the game. The ball must be thrown so that the “receiver” is able to catch it easily. The “sender” throws it with as much precision as possible. The “receivers” stands in a proper position to catch it, but can be caught off guard and miss the mark if not paying attention or if the ball was thrown improperly.



Similar in communication, the HCP sends the message to the patient with careful precision in order for the patient to “receive” it and respond accordingly. The HCP must be ready to “catch” the patient’s communication accurately and to respond with precision. So even when the HCP isn’t sending a message and verbalizing, she is

still carefully attending to the patient’s body cues, how the message is being delivered, so that the chances of “catching” the message are enhanced.

Every person is a communicator. You are always communicating.

The message is not necessarily a verbal one. Nonverbal messages are continually being sent and received during the communication process.

The message sent is not necessarily the message that is received. Influencing factors on the message could include things such as cultural differences, not tuning in to nonverbal and verbal cues, the physical setting where the communication takes place, as well as the type of relationship that exists between the sender and receiver.

All communication has a verbal, as well as a nonverbal, component. Make sure that your nonverbal behaviors support your verbal messages. Smiling, a stern facial expression, or a frown while speaking communicates different meanings to the patient. When the verbal message is incongruent with the nonverbal message, the nonverbal message becomes stronger and is more likely to be believed by the patient.

Communication Guidelines

The initiative in communication fluctuates depending on the purpose of the interaction. Initiative refers to who begins a discussion and determines the choice of content. Whether the HCP or the patient takes the initiative depends on the length of time available, the acuteness of the situation, and the goals to be met through the communication process.

Encourage the patient to be spontaneous.

When the patient is talking spontaneously, she is more likely to bring out useful information. She may start off with a spontaneous account of an event and if prompted to keep talking, will bring out all kinds of relevant material. By using minimal verbal activity, the HCP has thrown the initiative to the patient being interviewed, thus inducing spontaneity.

Identify, acknowledge, and respond to significant cues.

These may be words, facial expressions, acts, or gestures. There are certain key words that the patient may bring up and repeat several times, or statements that he may make very emphatically. A great deal will come out of it if the HCP follows the communication carefully. You should not pull questions out of the blue to ask the patient. Rather, you should attempt to introduce only material to which the patient has already referred and should focus on one or another lead that has already been expressed.

Facilitate the expression of feelings through communication.

You can never be sure where the therapeutic relationship is unless the patient is able to express feelings about some topic, person, or event. When feelings come through spontaneously, they bring clusters of facts with them. The patient should be encouraged to express feelings related to the “here-and-now,” not the deep-seated issues that s/he may be dealing with in therapy sessions. Examples of the “here-and-now” issues might include what brought the patient into the hospital, coping strategies, reactions to interventions, and self-management strategies.

Process:

- Acknowledge the feeling or expression of feelings.
- Allow for the feeling to be expressed; encourage it, give permission.
- Remember that it is very difficult to express how one is feeling. Keep in mind:
 - there is a history with expression about feelings
 - societal and cultural values come into play
 - we experience feelings about feelings
 - people fear they will lose control
 - people may have an actual lack of control
 - people feel combinations of feelings and various intensities of feelings
 - the closer the feelings are to dealing with you and me in the present, the more difficult they are to express.
- Identify our response to the patient’s expressed feeling
- Help the patient describe personally relevant feelings in concrete and specific terms.
- Help the patient become aware of the feeling he has about the feeling and label them.
- Allow the patient to express feelings in small doses.
- Allow the options for expression of feelings.

Facilitate appropriate action for coping with feelings.

- Give them a sense of control.
- Increase their awareness about problems related to feelings they are having. Provide them with an alternative frame of reference.
- Help them look at alternatives for action.
- Allow them to “be stuck” at a feeling if appropriate.
- Release energy associated with the feeling.
- Utilize knowledge re: depression, grieving, guilt, etc...

Communication Skills

Listening and Attentiveness

Attentive listening involves creating a climate in which a patient can communicate, giving the patient a sense of security and enhancing openness. It also involves communicating interest and respect for the patient, as well as the desire to want to understand the patient. Attentive listening enhances your credibility and may increase treatment compliance. The following behaviors are ones that reflect attentiveness and active listening skills.

Posture/Body Position

Whether you are sitting or standing, your posture should be relaxed. If possible, your upper body should be leaning slightly forward toward the patient. This communicates that you are interested. An open-armed, open-stanced posture is more welcoming than having your arms stiffly crossed.

Non-Verbal Reinforcers

Utilizing non-verbal reinforcers, such as eye contact, a smile, or a nod, are often enough to communicate to the patient that you are with them and are encouraging them to continue their verbalization. Eye contact while the patient is talking can reinforce the patient to talk more on the same topic. Good eye contact when you are speaking can help you be more persuasive. Be aware, though, of cultural differences. For example, some cultures – such as the Native American, Japanese, and Puerto Rican cultures – may prefer a limited use of direct eye contact. Each patient population should be assessed accordingly.

Communication is most effective if both parties are positioned so that their eyes are at the same level. For example, if you were standing over the patient’s bed, looking down at the patient, there is a difference in the flow of communication. This position can reflect a symbol of “power” or “control” and it may be more difficult to engage the patient in a conversation.

Personal Space

The amount of personal space that a patient requires will differ from patient to patient. Most therapeutic conversations take place within a social distance. Again, cultural differences may come into play; for example, American Indian, Afro-American, Pakistani, and Asian cultures generally require greater interpersonal space for successful interaction. Patients that are experiencing difficulty in trusting others and who have high anxiety

levels will need more physical space between themselves and you. More space may be needed for paranoid patients or a patient who is just admitted to the inpatient unit. Assessment of non-verbal cues will assist you in determining the patient's needs (i.e., patient shifting position, actually moving away slightly, or anxious behaviors).

Timing

Timing of communication is an important factor to consider for successful communication. You should assess the patient's behavior to determine their energy level and emotional readiness to actively participate. Planning for the communication during times when the patient is more receptive is not only more efficient, but is respectful of their needs as well.

Physical Setting

The physical setting is also an important factor to assess prior to interacting with the patient. For example, asking or communicating sensitive information to the patient is not appropriate at the inpatient central desk. This conversation will be more effective in a more private setting, such as the patient's room or a private conference room. An appropriate environment is free from things that may distract either you or the patient.

Facilitative Comments

Facilitative comments consist of one word or a few words. They indicate to the patient that you are listening and can encourage the patient to go on. The purpose of all brief facilitative comments is to communicate your attention, interest, and encouragement. A few examples of facilitative comments include:

- "Ummm-hmmm..."
- "Oh?" "Then?" "And?"
- *Repetition of one or two key words*
- "Can you tell me more?"
- "How did you feel about that?"

Verbal Following

Demonstrating verbal following behavior clearly shows that you are listening to the patient. This means that your questions and comments follow the specific content of your patient's communication, usually from the last remark the patient has made. Using this skill means responding directly to the concerns the patient is expressing at that time.

Patient: "I'm really upset today!"

Verbally Following: "What happened today that makes you upset?"

Not Verbally Following: "You need to get ready for OT now. They will be here shortly."

All of these skills will demonstrate to the patient that you are interested, that you respect the patient, and that you have a desire to guide the patient in meeting his treatment goals.

Non-Verbal Communication Skills

Using silence: utilize absence of verbal communication. An interested, expectant silence encourages the patient to verbalize. It gives the patient an opportunity to collect her thoughts, to think through a point, or to consider introducing a topic of greater concern than the one being discussed. Much non-verbal communication occurs during silence. A momentary loss of interest on your part can be interpreted as indifference.

Touch: a significant method for showing concern, reinforcing identity, and acknowledging the patient's individuality. It can stimulate both negative and positive reactions, depending on the circumstances of the interaction, cultural meaning, and personal meaning for the patient. The HCP should assess the patient individually before this communication method is used.

Verbal Skills

Giving broad openings: allowing the patient to take the initiative in introducing the topic.

"How are you today?"

"What are you thinking about?"

Encouraging responses: words and statements used to give an indication that you are listening attentively and interested in having the other person continue.

Patient: "So I guess it was because I was scared, I ran away, but you probably aren't interested."

HCP: "Yes, I am interested." "And then? Go on."

Making observations: verbalizing what is seen. This technique is especially useful in relating to very quiet patients. By voicing his perceptions, the HCP offers the patient something she can respond to.

"You seem more comfortable today."

"I notice that you're rubbing your shoulder."

"You are frowning."

Reflecting: repeating the patient's statement, using her words. Reflecting encourages spontaneity; communicates to the patient that you want her to continue with this topic of conversation.

Patient: "I can't sleep. I stay awake all night."

HCP: "You can't sleep?"

Paraphrasing – rephrasing the cognitive part of a message. This tells the patient whether or not his idea has been communicated. He is encouraged to continue. However, if he has been misunderstood, the idea can be reworded more clearly. This enables the patient to determine whether the message is coming through as he intended.

Patient: "I wonder how my children are doing at home. I've never been away from them before."

HCP: "You are not sure how they are managing without you?"

Reflecting feeling: rephrasing the affective, or emotional, tone of a message.

Patient: "I wonder how my children are doing at home. I've never been away from them before."

HCP: "You sound sad that you are away from your children."

Seeking clarification: seeking to make clear that which is not meaningful or that which is vague.

*"I'm not sure I know what you mean."
"What did you have in mind?"*

Perception checking: describing what you perceive to be the patient's inner state in order to check whether you understand the meaning of her behavior – verbal and non-verbal. You describe what you have observed and then state in a tentative way the feeling you think the patient may be having. You should indicate no approval or disapproval in your statement. You then give the patient a chance to validate the accuracy of your observation.

"I see you tapping your feet on the stool as I talk. Are you nervous about something?"

"I get the impression from what you just said, and your tone of voice, that you are angry with me."

"From your expression, I can't tell whether you are confused or irritated."

Exploring: delving further into a subject or idea. Exploration is frequently indicated. Other patients may deal superficially with a topic, testing to see if the HCP is interested enough to go further. The HCP should avoid probing or prying. If the patient chooses not to elaborate, the HCP should respect the patient's wishes.

"Tell me about that."

"What kind of work?"

"Would you describe it to me?"

Summarizing: organizing and summing up that which has gone before. Seeks to bring together the relevant parts of the discussion and to give each person an awareness of the progress made toward greater understanding. It omits the irrelevant and organizes the pertinent aspects of the interaction.

"You've said that..."

"During the past hour you and I have discussed..."

Supportive confrontation: diplomatic response that points out discrepancies in the patient's communication or behavior. By stating his own perceptions, the HCP presents an alternative thought to the patient to consider.

"You say you feel comfortable, but it looks like it's hard for you to talk about this."

Questions: can be open or closed.

Open: Elicit perceptions and feelings, encourage patients to elaborate.

Closed: Are used to elicit facts, usually one or two word responses.

Barriers to Effective Communication

Changing the subject or shifting the focus of the conversation by responding to some insignificant aspect of the patient's conversation. We often do this unconsciously to get to something we want to discuss or to get away from a topic we are uncomfortable with.

Patient, looking sad: "I missed my 16-year-old's birthday party."

HCP: "When was her birthday?" (does not focus on the sadness)

Giving own opinions or advice:

The HCP states her own opinions and ideas in such a way that it hinders the exploration of the patient's problems. The HCP tells the patient what to do. There is a difference between giving advice and giving information.

Advice takes responsibility away from the patient. Giving information is to supply the patient with data on which he can base a decision.

Inappropriate reassurance:

Giving inappropriate reassurance usually blocks further expression of feeling. It also devalues the patient's feelings and discourages accurate perception of what is happening.

"I wouldn't worry about that." "Everything will be all right." "You're coming along fine."

Jumping to conclusions:

Jumping to conclusions occurs when the HCP responds to part of a situation or problem expressed by the patient as if the entire situation or problem had been stated. The HCP jumps to conclusions without exploring what the patient is trying to communicate.

Patient: "I'm going home tomorrow."

HCP: "Great!" The patient is actually scared to death, and it isn't great.

Inappropriate use of facts:

The HCP uses facts to deal with an emotional issue, rather than focusing on the feelings.

Patient: "I'm really scared that when I go home, I'll start to have hallucinations again."

HCP: "Well, we know that about 50% of all patients with schizophrenia will relapse within one year." While the fact may be correct, the HCP should have been focusing on the "scared" piece.

Moralizing

When the HCP inserts his own values into the communication, the patient is likely to stop communicating, for fear that the HCP will judge the patient's behavior/thoughts.

Patient: "I think that my schizophrenia is a punishment for being gay."

HCP: "God doesn't punish people by giving them a mental illness."

Irrelevant or stereotyped comments:

"Really," "Cool," "Right on," "Wow," "That's the way it goes."

Interrupting

Patient: "I'm really uncomfortable going to group today because that crazy guy will be there."

HCP: "It's important that you go to group, though."

Patient: "But I really think..."

HCP: "You need to go to group now; you'd better get started or you'll be late."

Summary

This section has reviewed the key components of the therapeutic relationship, including the differences between a therapeutic relationship and a social one; the therapeutic use of self; and characteristics of the effective helping professional. This section also included general principles of communication, listening and attentiveness, and communication skills. Knowing what the therapeutic relationship should be like, as well as knowing some of the skills of communication with the psychiatric patient, can facilitate the patient's recovery.

Arnold and Boggs (1995) describe several general concepts to keep in mind when verbally communicating. To promote effective communication:

- Keep messages clear, honest, and to the point
- Keep language as simple as possible, gearing it to the patient's educational and developmental level, as well as their learning readiness. In essence, speak in the patient's every day language, defining unfamiliar terms and concepts when necessary.
- Verbalize ideas in a logical sequence, relating new ideas to familiar ones.
- Repeat key ideas to reinforce information.
- Use as many sensory communication channels as possible when reinforcing key ideas with the patient.
- Seek feedback from the patient to validate the accuracy of information you are receiving.

Applying What You've Learned...

We recommend that you do one or more of the following activities to apply what you have learned in this section:

1. Observe an experienced staff member in a therapeutic relationship with a patient.
2. Observe an experienced staff member using effective communication skills.
3. Practice therapeutic communication with a patient.

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Internet Resources

www.ahima.org: American health Information Management Association

www.himinfo.com Health Information Management

Directions for Submitting Your Post Test for Contact Hours

To obtain a certificate of completion for this home study program, please complete the post-test and evaluation on the next few pages. The date on your certificate of completion will be the date that your home study is received. **Any materials received with a postmark after the expiration will be discarded.**

HealthEast, HCMC, & MVAMC

If you are an employee of HealthEast, HCMC, or MVAMC, you may send the post-test and evaluation to TCHP for processing. Your post-test will be returned to you through your hospital. It cannot be mailed to your home.

Paid Participants

If you are not an employee of one of the TCHP hospitals, please send the post-test and evaluation to TCHP with a check for \$12.00. Please make check payable to **TCHP Education Consortium** and mail to:

**TCHP Education Consortium
Capitol Office Building
525 Park Street, Suite 120
St. Paul, MN 55103**

Your post-test will be returned to you with the certificate of completion.

Patient Care Post Test

Please print all information clearly and sign the verification statement:

Name _____
(please print legal name above)

Birth date (required)

M	M	D	D	Y	Y	Y	Y

Format: 01/03/1999

For HealthEast, HCMC, or MVAMC, employees only:
Hospital _____ Unit _____

Personal verification of successful completion of this educational activity (required):

I verify that I have read this home study and have completed the post-test and evaluation.

Signature

- 1) A patient asks for your home phone number so she can call you if she needs you. You give your phone number to her.
 - a) Boundary challenge
 - b) Boundary crossing
 - c) Boundary violation
 - d) None of the above
- 2) Sue, a very friendly and caring nursing assistant, is known to frequently give hugs to patients.
 - a) Boundary challenge
 - b) Boundary crossing
 - c) Boundary violation
 - d) None of the above
- 3) Who can access a patient's information without authorization?
 - a) a Social Worker investigating possible Vulnerable Adult Maltreatment
 - b) a reviewer for the JCAHO survey
 - c) the hospital attorney
 - d) all of the above
- 4) The mother of a patient calls to inquire about her daughter's condition. What do you need to know?
 - a) if the patient has given permission for the mother to receive information
 - b) if the patient has signed a release form
 - c) if the patient is incompetent
 - d) all of the above
- 5) The employer of a patient calls after he heard a rumor that his employee had been admitted for a psychotic break. What do you tell him?
 - a) "By law, I am not allowed to give any information out."
 - b) "I'm sorry, but I cannot give out any information."
 - c) "I can't give you any information; here is the number for the Health Information service."
 - d) any of the above responses would be appropriate
- 6) You and your patient are having a conversation on a 1:1 basis when your patient confides to you that he was the person who killed two people recently in a currently unsolved crime. He asks you not to tell anyone. What do you do?
 - a) don't tell anyone
 - b) call the police
 - c) inform the patient that professionally and ethically you cannot keep this information confidential
 - d) tell the psychiatrist confidentially
- 7) Are police deputies allowed to bring their guns onto the psychiatry unit?
 - a) Yes
 - b) No
- 8) What methods are used to provide physical safety in the inpatient unit?
 - a) all sharp objects, lighters, razors, and glass objects are removed from patient on admission
 - b) only education and "PG" rated movies are allowed
 - c) visitors are checked for contraband
 - d) all of the above
- 9) Signs of being over-involved in a therapeutic relationship include:
 - a) visiting patient during off-duty hours
 - b) having strong emotional feelings about how other staff treat your patient
 - c) giving extra attention to a patient
 - d) all of the above
- 10) The term used to describe the unconscious feelings and attitudes a **patient** has toward a HCP based on previous relationships is:
 - a) detachment
 - b) countertransference
 - c) transference

- 11) The use of silence can be an important communication skill.
- a) True
 - b) False

Evaluate the following comments:

- 12) Patient: “I’m really frustrated today.” HCP: “I see that you’re pacing a lot – it looks like you are frustrated.”
- a) Effective
 - b) Barrier
- 13) Patient: “I’m not sure that I’m ready to go home yet.” HCP: “You’ll do great.”
- a) Effective
 - b) Barrier
- 14) Patient: “I want to go home right now.” HCP: “You seem to be frustrated and angry – would you like to talk about that?”
- a) Effective
 - b) Barrier

Expiration date: The last day that post tests will be accepted for this edition is **December 31, 2018**—your envelope must be postmarked on or before that day.

EVALUATION: PATIENT CARE IN PSYCHIATRY

Please complete the evaluation form below by placing an "X" in the box that best fits your evaluation of this educational activity. Completion of this form is required to successfully complete the activity and be awarded contact hours.

At the end of this home study program, I am able to:	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. Identify the purposes of boundaries in patient and staff interactions in the psychiatric setting.					
2. Define concepts related to boundaries, including challenges, crosses, and violations.					
3. Review standards and guidelines related to patient-staff boundaries in the health care setting.					
4. Identify risk factors that contribute to boundary violations.					
5. Review legal mandates for confidentiality of patient information.					
6. Identify situations in which patient confidentiality may be breached.					
7. List information not to be released regarding psychiatric patient confidentiality.					
8. List information which should not be accessed related to patient confidentiality.					
9. Describe the elements necessary to have a therapeutic milieu.					
10. State the role of each staff member in providing and managing a therapeutic milieu.					
11. Differentiate between a social and a professional/therapeutic relationship.					
12. Explain the elements of a therapeutic relationship.					
13. Describe elements that are not part of the therapeutic relationship.					
14. Describe the elements of therapeutic communication.					
15. Identify the therapeutic use of "self."					
16. Define the terms "transference" and "counter-transference."					
17. The teaching / learning resources were effective. <i>If not, please comment:</i>					

The following were disclosed in writing prior to, or at the start of, this educational activity (please refer to the first 2 pages of the booklet).

	Yes	No
18. Notice of requirements for successful completion, including purpose and objectives		
19. Conflict of interest		
20. Disclosure of relevant financial relationships and mechanism to identify and resolve conflicts of interest		
21. Sponsorship or commercial support		
22. Non-endorsement of products		

The following were disclosed in writing prior to, or at the start of, this educational activity (please refer to the first 2 pages of the booklet).

23. Off-label use		
24. Expiration Date for Awarding Contact Hours		
25. Did you, as a participant, notice any bias in this educational activity that was not previously disclosed? <i>If yes, please describe the nature of the bias:</i>		

26. How long did it take you to read this home study and complete the post test and evaluation:
 _____hours and _____minutes.

27. Did you feel that the number of contact hours offered for this educational activity was appropriate for the amount of time you spent on it?
 ___Yes
 ___No, more contact hours should have been offered
 ___No, fewer contact hours should have been offered.

Expiration date: December 31, 2018
