

# Psychiatric Observation: A Skill Worth Developing

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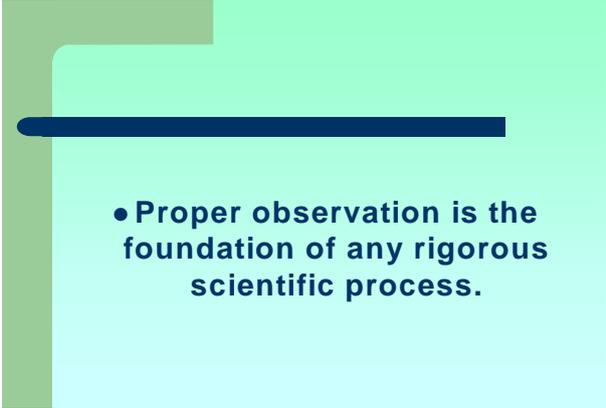
## Introduction

Nurses carry out a number of prescribed, autonomous, customized or other interventions with patients as part of their everyday activities. However, at the core of these interventions lies a crucial step which precedes, follows and guides nurses in their activities. It is observation which determines the relevance, execution and follow-up of interventions. This step is so significant that it should be integrated into any nurse's training. More than a century ago, Ducroly, an educator who continues to influence active pedagogy, wrote: "If we're not prepared to observe clearly and precisely, how can we have correct or fair ideas and precise judgments about subjects and the relations among subjects, or about more complicated subjects – those belonging to the realm of individuals and societies and their relations?" (translated from: <http://freinet.org/educpop/PFPA/observation.html>).

Observation has been the foundation of every scientific method since Antiquity. The need for observation still applies to the nursing profession as developing new knowledge is based on empirical data, meaning data which can be observed through experimentation. Observation remains an essential determinant in all scientific branches.

## Observation – the foundation of data-gathering

Observation can be defined as a focused and attentive look at a person or situation of interest. It is like pressing pause during a movie in order to focus or concentrate on a subject in order to analyze its details and to monitor its evolution. Observation entails an active, objective (free of judgment or tampering) follow-up ([http://fr.wikipedia.org/wiki/M%C3%A9thode\\_scientifique](http://fr.wikipedia.org/wiki/M%C3%A9thode_scientifique)). When observing a patient, we participate in a process in which we develop the history of his problem, its treatment and progress. We are thus active participants in the therapeutic, scientific method.



• Proper observation is the foundation of any rigorous scientific process.

Observation is therefore an essential skill that every nurse must master. Some people have a natural ability to observe and recognize important details, but carrying out a systemic observation is a learnt process.

Observation is not as easy as it seems, as it requires using our intellectual, emotional and organizational abilities in addition to focusing on a subject. French Encyclopaedist

Denis Diderot no doubt had this in mind when he stated: "Facts are gathered through observation, combined through reflection and validated by experimentation."

## Psychiatric observation: *an unavoidable requirement in caregiving*

Every branch of caregiving requires that its practitioners pay attention to the patient; however, this requirement takes on another dimension in psychiatry in which attitudes, facial expressions, words and silence each carry their own meaning in the psychiatric symptomology (semantics). In nursing, observation serves a different purpose. Above all, it

### Observation in psychiatry

- Participating in the definition or confirmation of the psychiatric symptomology.
- Understanding the problem to know how and where to act.
- Preparing for potential violence or agitation to protect oneself.

allows nurses to gain a better understanding of the patient and his reactions in order to determine the cause of his suffering. Awareness helps the nurse determine where and how to react to assist the patient dealing with a mental illness and its consequences. In addition, being on the lookout for manifestations of mental illness also helps the nurse protect herself from an unexpected outburst of violence. Observing the first signs of exacerbation or frustration is critical to avoid becoming a victim of violence as mentally ill patients are often

vulnerable to these sentiments or overwhelmed by their pathology.

### Objectives of observation in psychiatry

As in other branches of caregiving, the goals of psychiatric observation are:

- Understanding the patient's situation;
- Identifying signs of pathology;
- Trying to identify the causes of that pathology;
- Detecting and recognizing the patient's suffering in order to plan customized interventions;
- Following up on the patient's reaction to the treatment;
- Developing a therapeutic plan;
- Monitoring its application and the evolution of the patient.

### Rules for observation

- Remain objective throughout the observation.
- Do not be judgmental.
- Pay attention and focus on the subject.

### *Observation*

Learning how to observe a psychiatric patient is not as easy as it may initially seem because our physical, intellectual and emotional senses may cloud or modify our perceptions of the individual.

The first rule is to be **objective**, which means being as emotionally neutral or impartial as possible. Judging, approving or modifying another individual's behaviour or manners is not observing; it is

simply using our senses to capture a visual, auditory or physical impression, a somewhat complicated task. When confronted with a given situation, our normal reaction is often to judge others and to develop tenacious biases which influence our behaviour. Objectivity requires that any judgment be reserved during the period of observation and reinstated once more detailed information has been gathered.

**Benchmarks for observation**

- 1- Gain on overall perception of the individual or situation.**
- 2- Get a detailed perception of his facial expression, attitude and behaviour.**
- 3- Broaden your knowledge of the individual's background, history and support network.**

Another important rule for a thorough observation is to be extremely attentive and to pay attention to the subject. Observation cannot occur without paying attention. It should also be remembered that our ethical standards require that we observe patients with professionalism and due diligence. Our perception of an individual and of his problems often influences our medical diagnosis and choice of treatment. It also guides our subsequent actions. Superficial observations, false perceptions, and hasty interpretations

and judgments can result in serious consequences, from isolating a patient without reason to an abusive use of physical or chemical restraints.

Nursing students or practitioners must understand the significance of making a precise observation. Writing down the observations in the patient's record is not only a legal requirement; it is also a fundamental professional act. Observing the patient is so essential that every aspect of this process needs to be analyzed in order to raise efficiency through questions such as: "How does one observe?", "What should be observed, and when?"

**Observation Process**

- Step 1: Passive reception of information. Visual image of the person or situation. Auditive perception of speech and tone of voice. Touching during the physical examination reveals many sensations: heat, induration, roughness, etc.**
- Step 2: Active verification of information:**
  - a) internal questioning by caregiver ("What am I seeing or understanding");**
  - b) questions, reformulations.**
- Step 3: Validating perceptions:**
  - a) questions to clarify details;**
  - b) patient's words or behaviour confirm or infer what caregiver believes he has understood.**
- Step 4: Interpreting perceptions: the patient is sad, anxious or suicidal.**

## How does one observe?

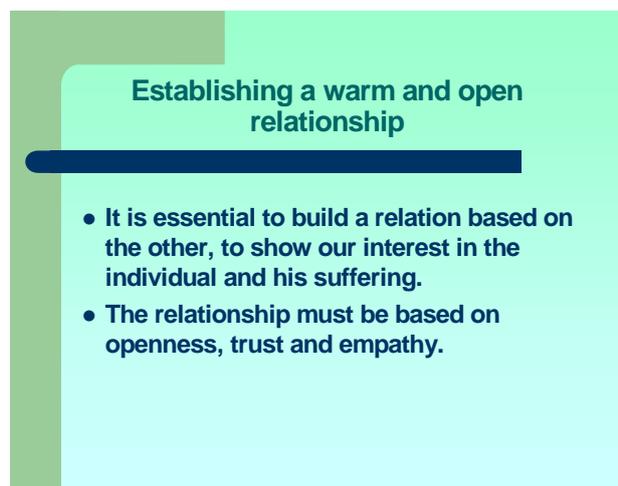
Humans are complex beings and the psychiatric semiology is replete with multiple facets. References are necessary to grasp all of its subtleness and complexity. Moving from a general impression of a subject to the more analytical details of his behaviour and personality is generally considered a proper method to carry out observation.

Observation is not only passive, even though it initially consists of the reception phase, in which we are in a state of expectation of what will happen next, and in a state in which our senses are exposed to the person's appearance, sound, words; in order to be efficient, the process of observation needs to be completed by an intellectually active phase through which we determine whether our perception is adequate. The active phase is that through which we seek out more details or explanations to validate our perceptions. "What do I perceive?" Is that really what I'm seeing, what I'm hearing? What else is there? What does it mean?"

### **Preparing for the meeting with the patient**

Our questions on observation also lead us to cover the conditions necessary for the nurse to gather the information. Openness to others and their experiences and listening are both essential tools. To these can be added empathy as a means of gaining knowledge and a deeper understanding of the individual because both the psychic and physical suffering of a person who has a mental illness are difficult to identify. That is why nurses must be particularly receptive and avoid overshadowing expressions that would otherwise be considered trivial.

### **Dialogue with the patient**



**Establishing a warm and open relationship**

- It is essential to build a relation based on the other, to show our interest in the individual and his suffering.
- The relationship must be based on openness, trust and empathy.

One of the best ways to observe the patient is to talk to him. This particular moment leaves room for an extended period of contact and for a conversation which more clearly centres on the information to be gathered. Discussion assumes adapted questioning methods and responding to the patient in a context which leaves room for a dialogue (Phaneuf, 2002, p. 248-315).

Information gathered during a discussion is broad in scope. That is why we must remember the importance of speech and speech analysis when parsing psychiatric data. Speech is often used to express a complaint which leads a person to consult, his family to refer him to a psychiatrist or police to drive him to the emergency room. It is worthwhile to pay particular attention to the complaint, its environment and all that it implies before meeting the patient.

### ***Measures to be taken before meeting the patient***

There are mandatory steps to follow before undertaking observation and the active phase of an interview. We should first establish a relationship built on trust which is essential for any exchange with a patient by:

- Introducing ourselves by mentioning our title: nurse, replacement nurse, head nurse, etc.;
- Stating that the reason for our presence is to gather information that is required for the patient's therapeutic plan;
- Specifying when necessary (i.e. with a distrustful person) that the information gathered will remain confidential and will be restricted to professional usage;

- Showing our interest in the patient and his health problem by engaging in a friendly conversation, building trust to put him at ease and encouraging him to talk to us;
- Giving the patient enough time to adapt to our intervention, avoiding pressing him with questions, varying the types of questions to obtain more information (open-ended, close-ended, circular questions, etc.) and remaining in the room even if we are bored.

### ***Tools at our disposal to facilitate observation during the discussion phase***

The discussion with the patient can be carried out informally in the form of a conversation with a clearly identified ending or with a questionnaire to identify the signs or symptoms of depression or anxiety (Beck or Hamilton scale). Many tools are also practical for gathering data and many of them are covered on this site. Their use is twofold: they can be used to gather more detailed information on specific elements (i.e. the family for the *genogram* or life experience through the *lifeline*) or they can generate discussions or generate awareness on the part of the patient.

### **When to observe?**

During contact, it is possible to observe the patient's discourse and behaviour. These exchanges allow us to determine his condition, to witness his reactions, to gather feedback on his problems, to observe his level of awareness and his contact with reality, and even to predict outbursts of violence. Observation can be carried out at any moment or during any activity. As the psychiatric pathology is often intermeshed in human relations, observing the patient always provides useful information.

How the patient behaves with others is a valuable source of information, be it with staff, other patients, in groups or in workshops. One must also distinguish data that absolutely

must be gathered upon the patient's admission from those that can be gathered later on. For example, if the patient is aggressive or suicidal, prioritizing can prevent unfortunate consequences. It also makes it possible to implement necessary measures early on. A more in-depth observation can be carried out at a later moment to analyze the patient's other aspects. In practice, observation lasts throughout the treatment and ends only upon the patient's departure.

### **Information to be gathered at admission**

- ✿ **Note the context of the admission: voluntary, emergency, involuntary.**
- ✿ **Evaluate the immediate risk to the patient: physiological condition (intoxication), violence against self or others.**
- ✿ **Observe the expression of thoughts and violent or aggressive connotations.**
- ✿ **Look for specifics regarding suicidal thoughts.**
- ✿ **Denote the state of awareness, orientation or contact with reality.**
- ✿ **Be on the lookout for the consumption of substances such as drugs, alcohol or medication.**
- ✿ **Gather information on the patient's recent behaviour: violent or disturbing behaviour, legal problems, mutilation, suicide attempt, etc.**
- ✿ **Ask whom to contact in case of an emergency.**

## What should be observed?

Many elements need to be observed in psychiatric care. The key to interpreting the patient's experience and to determining which interventions to implement at the secondary level often lies in minute details. The nurse's observation is not intended to carry out a diagnosis but rather to gather all necessary information in order to inform the physician on the patient's condition and to develop a therapeutic nursing plan. That is why it is necessary to observe many aspects such as facial expression, mood, body language, discourse and thought pattern, and to discuss the patient's environment, history, and so on.

### Overall impression

#### First impression

- 📌 **The first impression gives us a general perception of the person, his facial expression, his physical appearance, his clothing and his obvious behaviour.**
- 📌 **It can help us until we gather more information.**
- 📌 **It can also leave us with a false perception or stereotypes.**

Observation of the patient begins upon his arrival in the unit or during the first meeting.

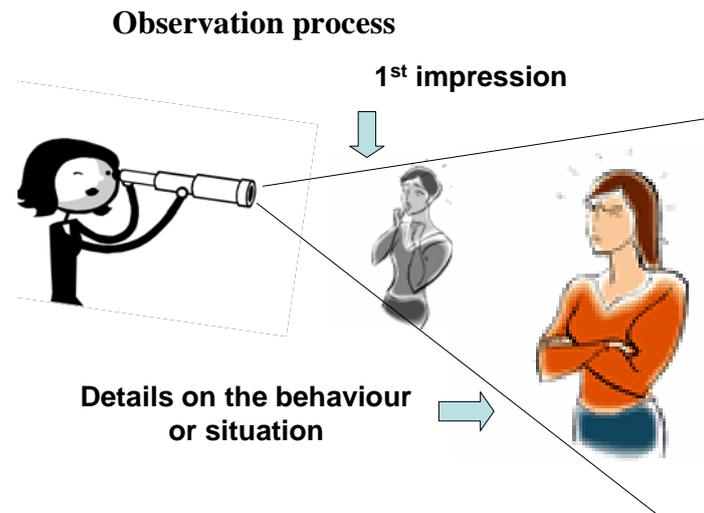
It allows us to gain a general perception, although imprecise, of the first image that the patient projects. In communications, it is often said that an impression is made during the first five minutes with a person; this might be an advantage, but it is also a trap of which we should be wary. The first impression always needs to be completed, specified and validated.

Our perception during initial contact allows us to notice many elements which compose our overall impression of the patient. More complete details might be noted later on.

These are some of the characteristics that strike us:

- **Age:** the patient seems younger or older;
- **Health condition:** the patient seems healthy, sick, tired, exhausted or is suffering;
- **Facial expression:** calm, smiling, indifferent, shy, closed, anxious, frightened, frozen, sad, sleeping, making faces;
- **Visual contact:** maintains visual contact, lowers eyes, avoids meeting others' eyes, closes eyes;
- **State of calm or agitation:** apathy, hands or arms waving or shaking, changes position;
- **Most disturbing behaviour:** agitation, aggressiveness, mutism, mutilation, attempts suicide;
- **Clothing:** acceptable, well-dressed, neglectful, shoddy, strange, eccentric;
- **Makeup:** discreet, acceptable, exaggerated, strange, eccentric;
- **Degree of orientation:**
  - **Space:** knows where he is, has difficulty orienting himself, feels lost (dementia);
  - **Time:** knows the hour, day, month and season (dementia);
  - **Relations with others:** recognizes others (caregivers, loved ones), confuses others' identities, doesn't recognize familiar persons (dementia);

- **Contact with reality:** awake, makes the right moves at the right time, engages with others or is apathetic, absent, not interested in everyday actions, in relations with others, appears to be in another world (psychosis, hallucination);
- **Posture:** slouching, defensive, turned inwards, foetal;
- **Gait:** slow, dragging, mannered, rigid, fast.



## **Information on the history of the patient's health problem and experiences**

Observation is carried out like a series of images, from panoramic to close-ranged. This approach allows us to cover the necessary aspects in psychiatry.

### **Health problem and its symptoms**

It is normal to first examine the information about the patient's reason for consulting or being referred by a psychiatrist. The objective is to gain a perspective expressed in our own terms, which also provides an opportunity to become familiar with descriptions of the patient's feelings (anxiety, distress from mourning, akathisia, insomnia, fatigue, exhaustion, morbid sadness, anorexia, bulimia, nightmares, hallucinations, etc.). For example, the patient might hear voices which insult him or which order him around. The patient might also be seeing or engaging in conversations with known or deceased persons or have creeping sensations throughout his body. He might be unable to go outdoors because he experiences moments of panic (i.e. has obsessive thoughts, fears that he might injure children, must endlessly repeat certain rituals, etc.).

### **Information on the patient's experience**

Information about the patient's background may vary. There are the obvious unfortunate events in a person's life, such as the death of a spouse or loss of employment which can generate an overwhelming sadness, a conflict which can lead to attacks of anxiety, abandonment by parents during childhood, alcohol abuse, a fight, violence towards a loved one or an urgent, undesired hospitalization, and so on.

Words, emotions, behaviour provoked by certain events and their consequences on the patient are also part of the baggage. For example, the patient may feel crushed, be unable to sleep or be fearful. He might think that nobody loves him, that he is inadequate and that it would be best if he disappeared. He might be contemplating suicide. He might be consuming drugs or alcohol, or be a compulsive gambler with no control over his own life. These elements must be considered in detail.

## The background of the episode that led to the consultation

To understand what a person is experiencing, it is often necessary to inquire about the origins of the problem and to monitor its evolution.

- **How did the problem begin?** Was it fatigue, exhaustion, persistent insomnia, a period of agitation, overexcitement, depression, anxiety, panic, irritability, isolation, autism, intolerance, aggression?
- **What triggered the episode?** Was it a conflict with a loved one, a problem at school or at work, fear, an act of violence against a patient, a violent reaction to the patient, work overload, a hardship (loss of a loved one, separation loss, unemployment, financial loss, loss of social status), narcissistic problem (failure, fear of losing face), a psychological shock (post-traumatic stress disorder resulting from rape or aggression), a physical illness (neurological disease: dementia, tumour, unidentifiable cause)?
- **What was the patient's reaction at that moment?** Was it low morale, desperation, leaving his home, a phase of depression or agitation, fear, panic, wandering, suicidal thoughts, hallucinations, delirium, a suicide attempt, a psychosomatic disease?
- **How was the situation experienced thereafter?** Did the psychological situation deteriorate, improve or remain unchanged? Was there an increase in the accompanying anxiety, insomnia or anorexia? Was there mutilation, suicidal thoughts and so on?

## Knowledge of the patient's experience and antecedents

In order to properly develop the nursing plan, it is recommended to know the patient's antecedents. For example, one should find out if he has already experienced a similar crisis (mania, panic, obsession, etc.), phases of depression or suicide attempts. It is also important to gather information on potential medical problems (hypertension, diabetes, cognitive deficiency, etc.). The physical examination component is covered at the end of this document.

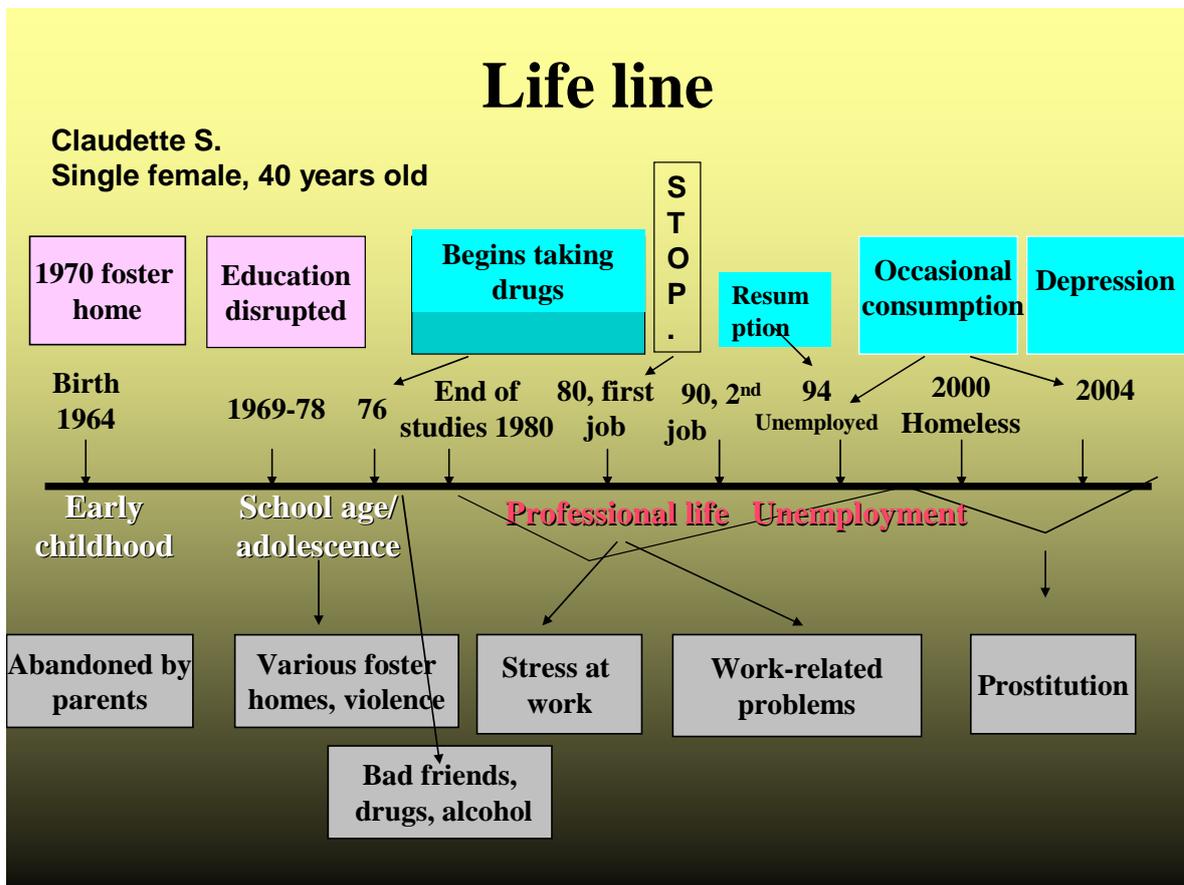


## Background

Knowing the patient's background is important in psychiatry. Questions must be adapted to each situation according to their relevance.

- Date and place of birth.
- Parents: biological, adoptive, living, deceased, separated, divorced.
- Foster home: reason for being put into home, number of families, duration of stay(s).
- Boarding school: reason for being sent to school, duration of stay(s).
- Current residence: upper, middle or lower-class.
- Family environment: healthy, happy, violent, indifferent or neglectful.
- Childhood: happy, sad, loving, abandoned, violent or abusive.
- Academic level: level achieved, drop-out, learning of a trade or profession.
- Events that marked one's life: death, marriage, rape, incest, birth of one or more children, marginalization, crime, boarding school, jail, poverty, alcoholism, drug use, family conflict, separation, divorce (patient or loved ones), illness, major surgery, chemotherapy (patient or loved ones).
- Problems with authorities: problem, penalty.

- Work: profession, schedule, required mobility, intellectual tasks, physical tasks (light, heavy), responsibilities (light, major), work environment (harmonious, conflictual, part-time, full-time, unemployed)
- Recreation: sports (walking, swimming, skiing, golfing, etc.), meeting friends and loved ones, theatre, movies, reading, hiking, hunting and/or fishing, intellectual games (cards, chess, scrabble, crosswords, Sudoku), no activities



- **Life line:** Practical strategy to isolate certain aspects of a person's history such as: evolution in alcoholism, drug or gambling addiction, teenager's problems at school. It helps put the problems in relation to the patient's experiences, to better understand their context and to assist the patient in developing self-criticism.
- (Margot Phaneuf, Infiressources, Carrefour clinique Clinical Crossroad, section :Santé mentale et Communication/Mental Health and Communication [http://www.infiressources.ca/fer/depotdocuments/La\\_ligne\\_de\\_vie\\_moyen\\_d\\_enrichissement\\_de\\_l\\_entretien.pdf](http://www.infiressources.ca/fer/depotdocuments/La_ligne_de_vie_moyen_d_enrichissement_de_l_entretien.pdf)).

### More detailed observation of expressions, attitudes and behaviours

In order to complete this chart, one must proceed with a more detailed observation of what the person is expressing. Required observations must be conducted in line with the patient's situation, condition, mental health problem and expressed needs.

Here are some of the main points that might be worth questioning or observing:

- **Facial expression:** calm, serene, anxious, indifferent, frightened, tense, tired, smiling, frozen, hilarious, sad, indolent, sleepy, distracted, grimacing, hard, crisp, jaws closed.

Amimia (lack of expression), paramimia (inappropriate expression) or echomimia (ecopathy, mimicking of another person's words or movements) can also be observed.

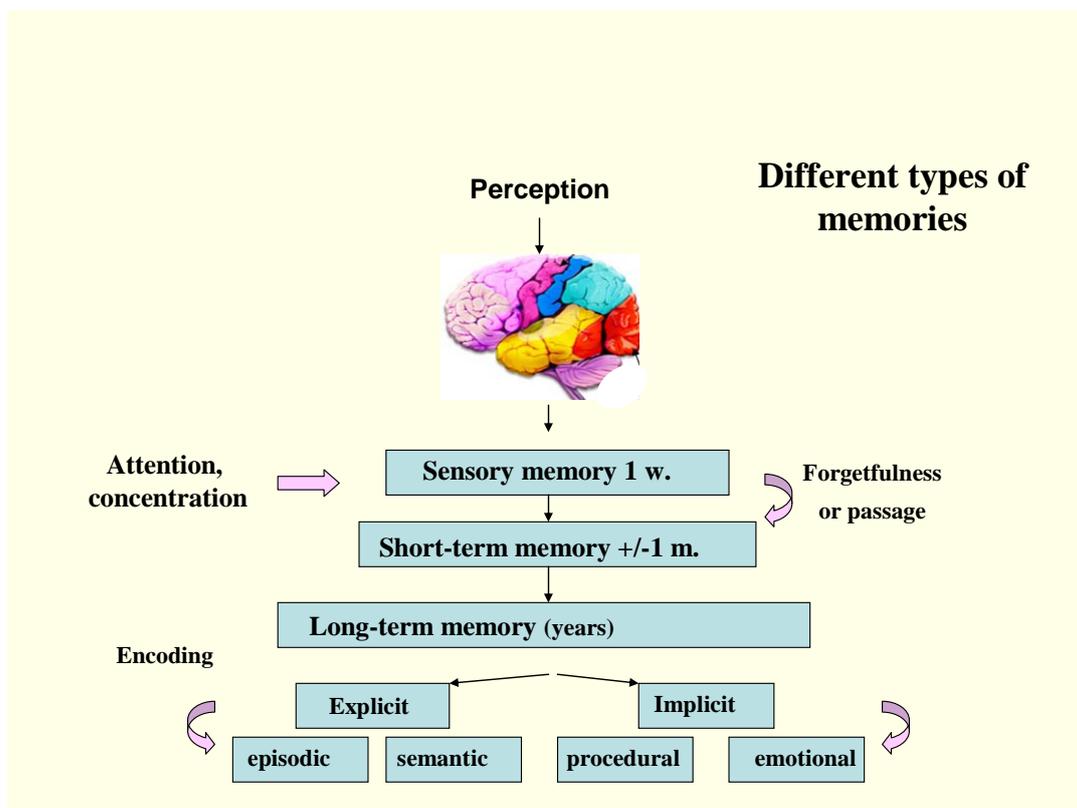
- **Gaze:** absent, empty, distracted, fixated, frightened, anxious, excited, downtrodden, tired, shy, funny, avoiding (cannot maintain visual contact), cruel, eyes closed or half-closed.
- **Movement and motor behaviour:** apathy, gesticulation, trunk movements, hyperactivity, agitation, involuntary agitation (extra-pyramidal reaction), ticks, suction movements with the tongue, protrusion of the tongue, grimacing, oculogyric movements; rubbing of fingers, hands, legs; akathisia. One might also observe immobility, echopraxia (involuntary imitation of another person's movements), agitation, a repetition of ritualistic movements (compulsions such as washing hands repeatedly, turning chair before sitting, etc.), raptus (act provoked by a sudden impulse and carried out), trembling, stereotypical gestures, perseverance (automatic repetition of certain movements or activities), motor slowdown, endless wandering, schizophrenic catalepsy (stupor, waxy flexibility).
- **Posture:** tonic, downtrodden, beaten, stooped, sleepy, straight, bent, sunken, slouching, laid back, stiff (schizophrenic catalepsy).
- **Gait:** fast, slow, hesitant, lagging, stiff, indolent, mannered, rigid or with small steps with one foot lagging, with blockage in movement (Parkinson's disease).
- **Attitude:** positive, negative, cold, informal, reticent, ludic (playful, makes jokes and puns), sceptical, defensive, irritable, resentful, aggressive, seductive, etc.
- **Mood:** happy, sad, depressed, stable, exalted, labile (shifting), anxious, euphoric, indifferent, distant, etc.
- **Voice:** weak, strong, monotone, monochord (without modulation), trembling, scratchy, low or high-pitched.
- **Personal hygiene or dress:** sophisticated, negligent, improper hygiene, eccentric, total absence of care.
- **Hair:** messy, scruffy, smooth, gelled (or covered with a sticky substance), short, long, properly combed.
- **Behaviour:** aggressive, violent, coprophilia (interest in feces), coprophagia (consumption of excrements), pica (eating everything one can get a hold of), suicidal act or gesture (overconsumption of medication, dissimulation of a weapon or rope), paraphilia (sexual perversions: necrophilia, fetishism, voyeurism, fugues, pyromania, kleptomania, exhibitionism, sado-masochism)
- **Addictions:** alcoholism, various toximania (medications: sleeping pills, psychotropic drugs such as morphine, heroine, cocaine, cannabis, hallucinogens, solvents, steroids, anabolic drugs, crack, amphetamines), tobacco, gambling, computer (chat), emotional dependence, workaholism.
- **Eating disorders:** Anorexia, bulimia, potomania (habit of drinking large quantities of water).
- **Sleep disorders:** insomnia, hypersomnia, night disorders (pavus nocturnus), nightmares, hypnagogic hallucinations (moment preceding sleep), hypnopompic hallucinations (when waking up).
- **Introspective abilities:** ability to understand own behaviour and to evaluate it realistically, self-criticism: absent, poor, good.
- **Patient's reaction to his problem:** denial, anxiety, anger, hostility, alteration of self-image, fear of madness, feeling of personal failure, feeling powerless, despair, fear of losing control, shame, guilt, regression, dependency. (Jean-Louis Senon. Conduite de l'entretien en psychiatrie.

<http://www.senononline.com/Documentation/telechargement/3cycle/Psychiatrie/des%20IR/Senon%20Conduite%20entretien%20psychiatrie> )

- **Silence:** some patients remain silent. Observe whether the silence denotes reflection, a surplus of emotion, resentment or anger. A sudden silence can indicate that the patient is about to react.
- **Energy:** the patient's physical or psychological strength. It is expressed by his motivation to act, to change, by the force that he can use, through the demonstration of his will-power. Schizophrenics frequently don't have the will to act. The person who is depressed is always tired, has little energy and does not have much will, which leads to discouragement. The manic patient possesses lots of physical and psychic energy. He can even become agitated to the point of exhaustion. Dependent patients often suffer from aboulia or the inability to act or make decisions through lack of will-power.
- **Motivation:** process which translates our commitment into action. It determines how that action is triggered and oriented. Motivation favours the successful outcome of our efforts by regulating the intensity of our output. It can be observed that:
  - The person expresses his lack of motivation;
  - Says nothing and is not interested in obtaining information or acting;
  - Says that he is willing to act or to change;
  - Expresses his motivation to change.

## Mental and mnesic abilities

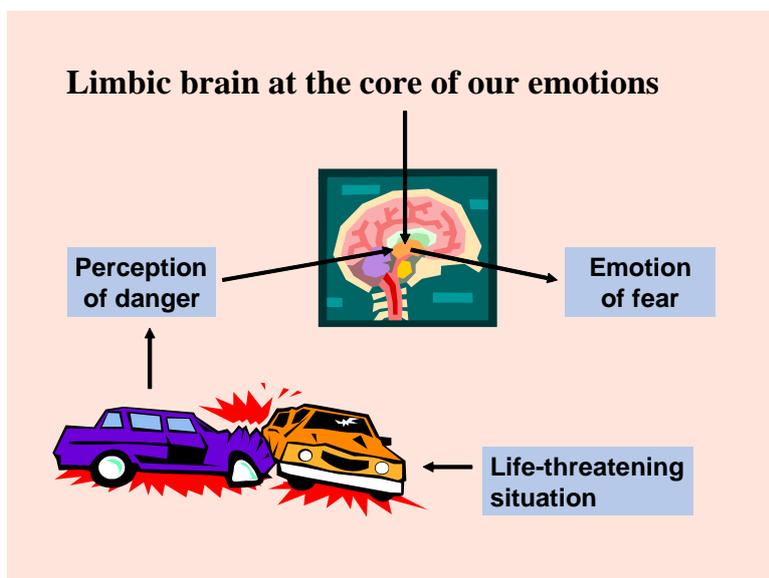
Those suffering from psychiatric diseases can experience problems with their memory's executive functions.



**Executive functions:** essential for functioning in society, at work, and for studying. A disruption at this level affects concentration, judgment, inductive and deductive reasoning, decision-making, and the ability to plan or calculate. Indecisiveness, ambivalence and inattention can be observed (Margot Phaneuf, *La maladie d'Alzheimer fléau de notre temps*, 2007, p. 125-130).

**Memory:** Memory problems appear when people have trouble remembering recent events (short-term memory), distant events (long-term memory), activities required for personal hygiene and daily activities (procedural memory). Other memory problems include the absence of words (semantic memory attacked), paramnesia (imaginary thoughts considered to be memories), false recognition, fabulation, agnosia (in dementia, trouble remembering shapes), aphasia, prosopagnosia (problem remembering faces), amnesia, hyperfamiliarity for unknown faces (demented person wrongly recognizes unknown persons) (Margot Phaneuf, 2007, p. 124-130).

## Emotions and affects



An emotion is a disorder, an **intense and temporary affect**, an agitation caused by a deep feeling experienced by an individual. Emotions cloud our judgment and guide our actions. When dealing with primary emotions, one is referring to affects or moods which result in an emotional or physical discharge which either increase or decrease or ability to act.

Affect is blunt or limited in certain pathologies such as schizophrenia or depression and

is said to be flat. The individual's face or gaze shows no expression, the voice is monotone, smiles are rare and hand or arm gestures are limited. The patient suffering from a bipolar disease wavers between increased reactions during a manic phase and flat affect during periods of depression. Emotions which can be observed include:

anxiety, fear, uneasiness, apathy, insecurity, restlessness, pessimism, defeatism, lassitude, melancholy, discouragement, affliction, despair, surprise, joy, gaiety, satisfaction, pleasure, serenity, confusion, dismay, effervescence, excitement, tenderness, love, desire, euphoria, exaltation, pride, exacerbation, intoxication, sadness, coldness, coolness, disdain, disgust, aversion, derision, cynicism, insensitivity, boredom, servility, scepticism, displeasure, mistrust, indifference, self-estrangement, repulsion, arrogance, condescension, spite, aversion, aggressiveness, brutality, hardness, animosity, hate, resentment, anger, guilt, cruelty, horror, sensitivity, egocentricity, pity, sympathy, generosity, compassion, empathy, withdrawal.

These emotions and many others are typical of certain mental health disorders. That is why it is essential to observe them. Examples in depression include:

- Flat affect, sadness, melancholy, morosity, negativity, anxiety, defeatism, bitterness, affliction, bereavement, discouragement and lassitude.
- Among persons suffering from paranoia or bipolar disorders: scepticism, mistrust, arrogance, coolness, condescension, anger and spite.
- Among hysterics: excitement, exaltation, desire, euphoria.
- Among schizophrenics: flat affect, indifference, disengagement, insensitivity, withdrawal, isolation.
- Among asocial or borderline personalities: arrogance, coolness, condescension, derision, cynicism, cruelty, spite, aversion, aggressiveness, brutality, hardness.
- Among persons suffering from phobias: fear, worry, insecurity, anxiety, anguish.
- Among severely disturbed persons, the following might be signs of preparing a suicide: disengagement (giving away possessions), sudden calm.

### **Emotions and self-esteem**

Self-esteem arises from the conviction that one possesses the necessary qualities to manage one's life. This feeling is influenced by the opinion that others reflect upon us, through our successes and failures in school, at work, in love and especially through our relationship with our parents. Self-esteem problems are often present among psychiatric patients. It is important to note their signs, such as:

- A tendency for self-deprecation;
- Lack of confidence in one's abilities;
- A tendency to focus on one's problems, failures and what one would like to be;
- Uneasiness, shame;
- False beliefs on oneself such as ugliness, obesity, skinniness, etc.
- A feeling of indignity that can lead to delusion.

### **Emotions and ability to socialize**

Individuals suffering from psychiatric problems often express signs of a disturbed personality. They express what they are deeply feeling within. Their emotions impregnate their behaviour and affect their ability to establish relations with others.

#### ***Ability to socialize***

Psychiatric problems may be obviously expressed when a person socializes with others, be it with his family, co-workers, classmates, in a psychiatric unit or in other social spheres. The nurse must observe the patient's behaviour or obtain information about his inhibitions.

There are many reasons why an individual may experience problems communicating with others.

- Difficult thought pattern (inconsistency, disorientation, agnosia) can result in communication problems. Some individuals may have trouble understanding the patient and vice versa.
- Alterations in perception are also a cause of significant woes, especially hallucinations and delirium, which impede communication.
- Coolness, withdrawal and lack of expression, among schizophrenics demonstrated in a hermetic, symbolic, neological or incomprehensible manner (word salads).
- Accelerated thoughts and excitement among patients in the manic phase make it difficult to initiate contact. Also disruptive are their susceptibility, aggressiveness, lability, mood and euphoria.
- Sadness, slow thinking and lack of energy to initiate a conversation are significant obstacles among depressed patients.
- Asocial patients and those with borderline personalities may express arrogance, cynicism or aggressiveness, which are significant irritants that block communication.
- Mistrust among paranoid personalities who tend to project, a trait which does not favour dialogue.

*Elements which should be observed are:*

- **Openness:** ability to turn to another person, to pay attention and to pursue a dialogue;
- **Logic of speech:** ability to follow and pursue a conversation and its logical flow;
- **Language used:** lack of vocabulary, word salads, neologisms, insults, curses, swearing;
- **Emotions expressed during contact:** politeness, softness, indifference, impatience, negativity, aggressiveness, impoliteness, superiority, arrogance, mistrust, spite, anxiety, fear, sadness;
- **Behaviour demonstrated:** expressive or threatening gestures, sulking, mutism, agitation, deambulation, violence;
- **Defence mechanisms used:** projection, intellectualization, humour, splitting;
- **Cognitive distortions:** generalizations, modal operators (self-talk phrases such as "I must" or "I should");
- **Delirium hallucinatory:** discourse expressing persecution, mania, somatic complaints, claims, etc.;
- **Signs of hallucination during exchanges:** attitude towards listening, addressing an imaginary being;
- **Demonstration of false beliefs (delusions):** reactions of suspicion, jealousy in speech, claims, somatic complaints, etc.;

## **Speech and thought**

Speech and thought disorders are especially noticeable in and a significant consequence of psychiatric problems.

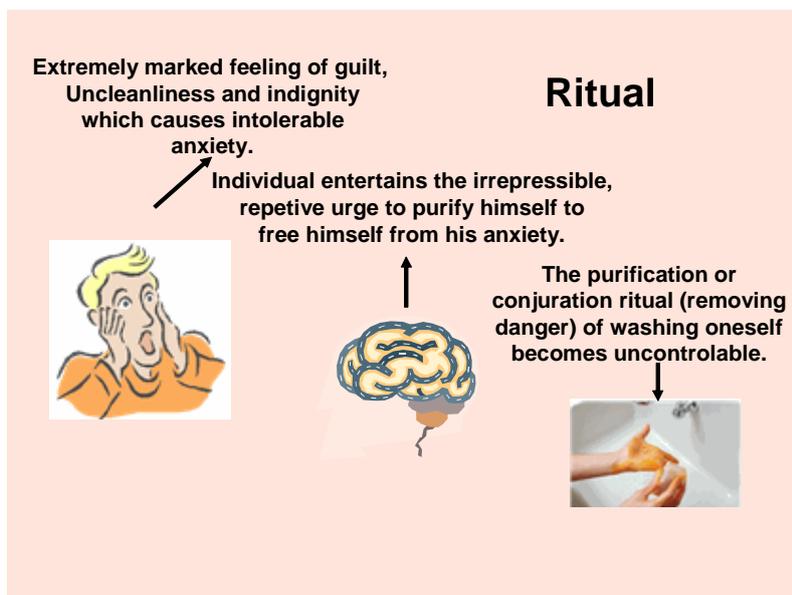
**Speech and delivery:** fluidity (rapid transfer from thought to speech), verbal fluency (ability to express a number of words over a given period), slow or rapid speech, logorrhea, cluttering, dysarthria, stuttering, mutism, fading (gradual decrease in speech's rhythm), blockage or obstruction of speech (pause, void in middle of conversation), wealth of vocabulary, absence of words, monosyllabic expression.

**Speech and logic (thought flow):** thought process accelerates (hypsychia) among patients suffering from a bipolar disorder. Circumstantiality (overabundance of words and ideas resulting in difficulty focusing on the object of discussion) may be present during the manic phase as well as tangentiality or disconnection of thoughts during a conversation. The patient might suddenly shift subjects and have trouble making associations, resulting in a loss of the flow of the conversation. Also observable may be: bradypsychia (slowing down of thought flow), slower delivery and a degradation of ideas which may even become inhibited among depressed persons (Denise Bruneau-Morin, class notes, 2002).

Among some psychotics, verbal delivery may even increase, resulting in illogical or incoherent thought flow, unrelated sentences, joking or word salads (Denise Bruneau-Morin, class notes, 2002). Other observations may include: echolalia (imitation of another's speech), palilalia (involuntary repetition of one or more words), stereotypy (repetition of meaningless words or phrases), neologisms (language unique to the schizophrenic who invents words that only he understands), glossolalia (unintelligible sounds and primitive language construction), scatology, swearing, coprolalia (language focusing on feces).

**Thought content revealed through speech and behaviour:** The following can be observed: aprosexia (inability to focus, make intellectual effort), state of awareness, altered awareness (somnia, temporal confusion, spatial or interpersonal disorientation), twilight or oneiroid state (diminished intellectual activity in favour of dreamlike images, similar to amnesia).

One may also observe: verbigeration (expressing incoherent and unrelated phrases),



obsessions (dominant ideas which overcome consciousness), compulsions (irrepressible urge to carry out certain actions such as washing oneself), fabulation, mythomania (inventing facts and characters), hypochondria (overexaggerated fear of being sick), pathomimia (mimicking a pathology), or Munchausen syndrome (chronic factitious disorder with physical symptoms so severe as to require multiple hospitalizations). There are also phobias, which are

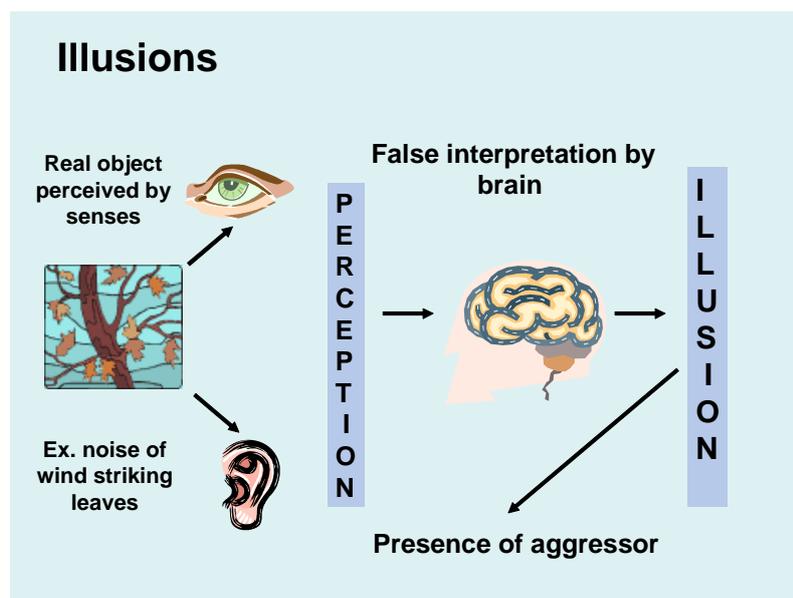
uncontrollable, exaggerated fears which occur even in the absence of an imminent threat, such as: agorophobia (fear of public spaces), acrophobia (fear of heights), arachnophobia (fear of spiders), microphobia (fear of germs), cancerophobia (fear of cancer) and claustrophobia (fear of closed spaces). One might also note depersonalization (impression of no longer being

oneself), derealization (feeling that one's environment is not real), suicidal or homicidal thoughts, illusions, delirium, and hallucinations.

## Thought pattern

A thought pattern refers to the logic and organization of thoughts. One soon notices whether a person is articulate and expresses concrete thoughts, is capable of analysis, judgment, deduction, induction, abstraction or is otherwise hermetic (hard to understand, obscure). Children and psychotics may express magical thinking, which is beyond the bounds of logic.

## Perception disorders



Perception is the act of perceiving internal or external stimuli which are then transmitted to the limbic brain, which is responsible for emotions, and then to the cortical brain for interpretation. Perception disorders include: illusions, hallucinations, delusions (religious, paranoid, hypochondria, persecution, filiation, megalomania, delusion of reference, jealousy. (Dicopsy.free [http://www.geopsy.com/courspsycho/pat\\_ho\\_generale.pdf](http://www.geopsy.com/courspsycho/pat_ho_generale.pdf)).

## Illusions

Illusions are false interpretations of an external event which really occurred. The senses capture the event, but the brain misinterprets it. For example, one might mistake the shadow of a coat peg for a person or a branch knocking a house for an intrusion. Illusions are common in Alzheimer's disease. The patient may believe that someone else is present upon seeing his reflection in the mirror or bath.

## Hallucinations

A hallucination is a perceptual misinterpretation that is worth observing.

### *Definition and etiology*

Hallucinations, which are pathological, but not all psychiatric by nature, are false perceptions which occur in the absence of external stimuli. They can occur at any given moment, but more likely in darkness.

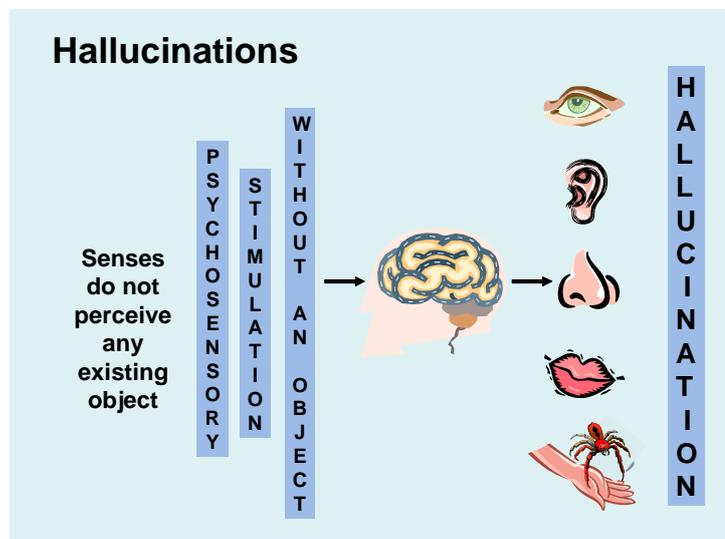
A treatable physical etiology might be present (i.e. as in delirium). These hallucinations might occur during strong bouts of fever, during physiological imbalances such as uremia, during

barbiturate or alcohol intoxication, and so on. People suffering from headaches, neurological pathologies (auras in epilepsy), vascular diseases, tumours or degenerative diseases such as Lewy body dementia and Alzheimer's disease dementia may also experience hallucinations.

### *Psychiatric characteristics*

At the psychiatric level, hallucinations can be detected in psychoses such as schizophrenia, paranoia, melancholia, bipolar diseases (mania) as well as in hysteria and acute depression.

**Sensory hallucinations:** can affect one or more senses.



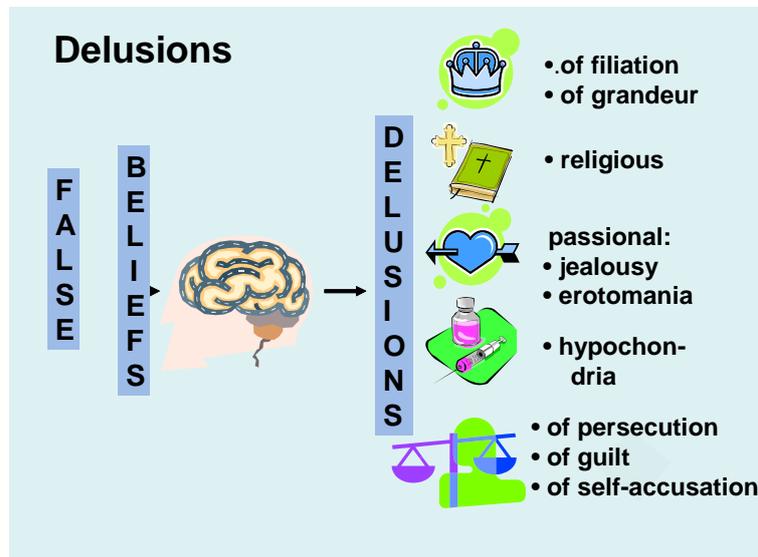
- **Auditory hallucinations (acoustico-verbal):** Most common form. The patient adopts a specific behaviour when communicating with someone (hallucinatory dialogue). He appears to be listening, to be afraid or to be running away. These hallucinations can take the form of musical notes, bell sounds, menacing voices, insults or orders (delusion of being controlled, an extremely common characteristic).
- **Visual hallucinations:** Less common and potentially frightening (vision of demons, flames). **Zoopsia**, in which the patient is under the impression that he sees animals, is symptomatic of delirium tremens among alcoholics.
- **Olfactory and gustatory hallucinations:** Rare. Patients suffering from gustatory hallucinations complain of an unpleasant, rotten taste and might believe that they are being poisoned. Epileptics under aura experience a metallic flavour. Olfactory hallucinations involve the perception of a nauseous odour such as gas, ammonia or putrefaction.
- **Kinesthetic hallucinations** cause a sensation of movement within the body or of the body within space.
- **Tactile hallucinations:** Affect the skin throughout the body and are experienced in the form of burning, heat, cold, tingling, creeping, itching, stinging or erotic rubbing sensations. There even exists a hallucinatory sexuality.
- **Cenesthetic hallucinations** affect deep or proprioceptive sensibilities. They affect the musculo-skeletal system as well as the internal organs. These hallucinations sometimes result in sensations of diabolical possession, gender alteration, physical metamorphosis, telepathy and thought intrusion.

It is important to observe how much the patient believes in his false perceptions when hallucinating.

**Psychic hallucinations** are non-sensorial. They involve the transmission of thoughts, telepathy, echo of thought or possession. The patient might believe he is being directed by the RCMP, the CIA or extraterrestrials. Psychic hallucinations should be diagnosed separately from hallucinosis, when the patient remains aware and critical of his hallucinations (i.e. Charles Bonnet Syndrome among blind persons).

## Observable behaviour:

- Listening attitude
- Facial expression of fear
- Desire to escape from a situation, to protect oneself (hiding, covering ears, listening to music)
- Hallucinatory dialogue (with an imaginary being)



## Delusions

Delusions are belief systems adopted by the patient because he is convinced they are true. They do not constitute errors of judgment, but rather convictions on certain topics.

The main types of delusions are:

- **Persecution:** The patient believes that he is being tormented or

attacked by others in the form of teasing, slander, repudiation, denigration, harassment, etc.;

- **Delusion of grandeur:** The patient is convinced of his own importance and will not lower himself to a level that he considers trivial. He believes that he deserves the best and spends extravagantly;
- **Delusion of being wronged (delusional revendication):** The patient expresses dissatisfaction over trivialities, believes he is the victim of injustice (i.e. files multiple lawsuits);
- **Delusion of influence:** The patient believes he is being directed by an outside organization, the mafia, the CIA or extraterrestrials;
- **Delusion of filiation:** The patient believes he is of royal lineage;
- **Passional delusion:** The patient experiences jealousy, erotomania (believes he is loved);
- **Hypochondrial delusion:** The patient is overwhelmed by his preoccupations with his health and body. He always believes that he is sick;
- **Delusion of guilt, indignity or unworthiness:** The patient believes he is worthless and is responsible for everything.

## Violence

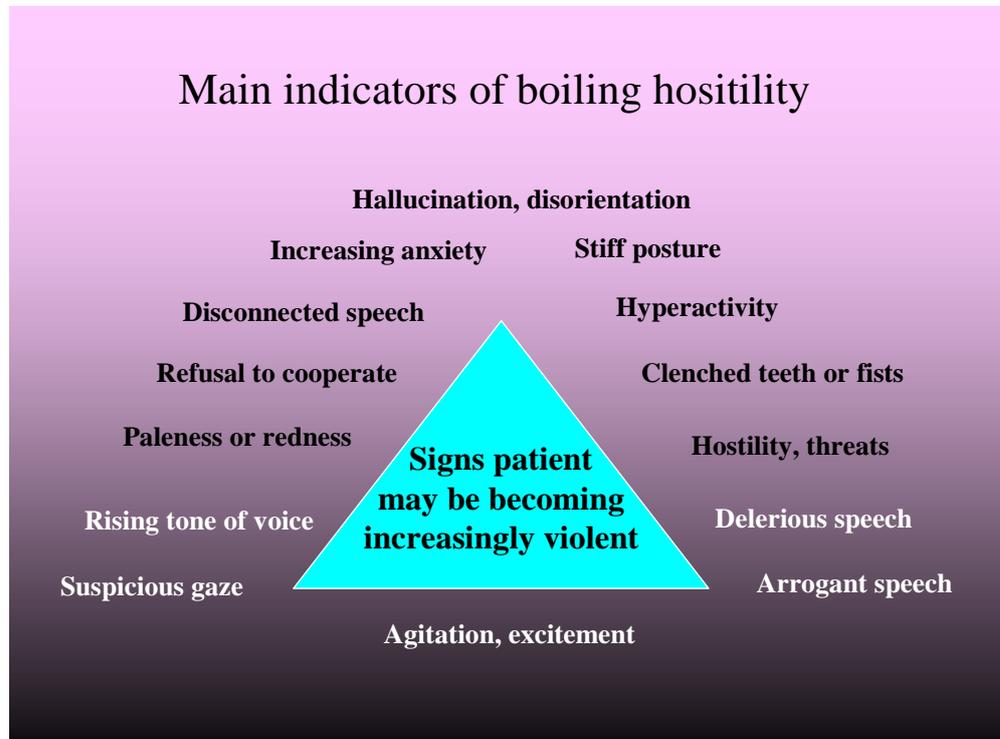
The mood of an individual suffering from a psychiatric problem is often unstable. He can be cool or distant. At home, aggressive behaviour leading to violence is not uncommon. It is important to identify the signs as early as possible to tailor a proper response in order to protect the patient and others around him. The enclosed figure illustrates how tension arises. Interventions before the occurrence of a violent outburst can prevent unfortunate situations. For preventative purposes, it is important to recognize the signs and symptoms of aggressive behaviour and to

avoid provocation (orders, denying attention, defensive behaviour, aggressiveness).

### Verbal attacks preceding violence

Verbal attacks are a sign of hostility or anger that can degenerate into violence. Recognizing their signs can lead to a timely intervention.

Verbal attacks can include: refusal to answer or cooperate, laconic response, rising tone of voice, arrogant speech, yelling, cursing, swearing, uttering threats. One should also look out for words that might indicate the presence of hallucinations or deliria. A sudden silence might indicate that a violent outburst is imminent.



### Typical facial expression before an outbreak of violence

- **Gaze:** fixed, insistent, haggard, distrustful, disoriented, frightened, dilated pupils;
- **Face:** anxious, redness, intense perspiration, dilated nostrils, intense respiration, paleness, clenched jaws and teeth;
- **Insults directed against caregivers and other persons:** swearing, insults or unfavourable descriptions directed against other person's physical appearance, name, race, or nationality with the intent to ridicule;
- **Behaviour:** agitation, wandering, akathisia, closed fists, excited movements, rigid posture, threatening gestures, hyperactivity (banging doors, tossing chairs, throwing objects);
- **Dangerous proximity:** During a violent outburst, the patient might approach the caregiver and try to touch, grab, push or hit her.
- **Sudden silence**

### Self-violence

The patient suffering from a mental health problem often directs his aggressiveness against himself (i.e. mutilation or suicidal thoughts).

## *Self-mutilation*

Self-mutilation is a self-inflicted wound intended to put an end to anxiety, frustration, sadness or boredom, or to alleviate guilt or self-esteem problems. Self-inflicted wounds allow the patient to remove the energy accumulated through anger by punishing himself if he is experiencing guilt, or to return to reality. The patient is unable to express himself otherwise, so he mutilates himself. Mutilation can include: scratching, bruising, burning, biting or cutting, the latter two being more common. Self-mutilation may even become a natural response when the patient is facing a problem.

Caregivers should observe:

- a) the situation and emotions at the time of the mutilation;
- b) the site and nature of the mutilation.

## *Suicidal thoughts*

It is extremely important to observe the patient's expression of suicidal thoughts, which can take on various forms.

- **Expression of suicidal thoughts:** The patient may evoke suicide by saying: "It's best that I simply disappear" or "Don't worry, I soon won't be bothering you", etc.
- **Suicidal blackmail:** The patient often casually talks about committing suicide. As it is impossible to determine whether he is serious, one must consider the act imminent.
- **Planning suicide:** The patient accumulates medicine, conceals a weapon or is planning other means to kill himself.
- **Suicide attempt:** The individual carries out self-destructive, self-mutilatory or suicidal gestures.

It is critical to follow up the patient's behaviour and to question him about his suicidal thoughts or plans to save his life.

## **Types of personalities**

Identifying the patient's personality helps us understand his way of being, how to initiate a relation with him and how to protect ourselves. The main types of personalities are:

- **Paranoid personalities** have a positive self-image and an exaggerated conception of their own importance. They are rigid, critical and distrustful.
- **Schizoid personalities** focus on themselves, don't externalize their emotions very much and experience problems establishing relations with others.
- **Schizotypal personalities** are eccentric, strange, experience relational problems and have a paranoid thought pattern.
- **Histrionic personalities** are governed by their emotions, seek attention and are theatrical.
- **Narcissistic personalities** have a tendency for self-admiration and self-directed libido.
- **Antisocial personalities** are manipulative, dysfunctional at the interpersonal level, and are characterized by deviant and marginal behaviour. Violence and aggression are possible traits.
- **Borderline personalities** are at the limits of a psychotic and a neurotic structure; they are



- **Arbitrary inference:** The individual reaches hasty conclusions without evidence to back them (i.e. "If she is off-hand with me, I must not interest her at all").
- **Mind reading:** The person talks as if he knew what was going on in another person's mind (i.e. "I know what he thinks of me" or "I know what you're feeling").
- **Magnification (catastrophizing) or minimization:** The patient always emphasizes what is negative and minimizes what is positive.
- **Modal operators:** The person creates overwhelming obligations through self-talk phrases (i.e. "I must..." or "I should..."). This often indicates the burden of perfectionism.
- **Narcissistic personalization:** Everything centres on the person in order to make him the victim (mistakes, responsibilities). Only he has problems. This focus on the ego can also be expressed through boasting (talents, achievements).
- **Dichotomic reasoning:** The individual makes qualified judgments. Everything is black or white, good or bad, perfect or not (i.e. "I failed this exam; I'm stupid" or "I lost my job, so my life is over").
- **Emotional reasoning:** The patient believes that his judgment, guided by emotions, is true (i.e. "I can't work with him because he hates me").

## Cognitive distortions

- Errors of judgment which can feed anxiety, depression, the person's ill-health and which can also create unhealthy obligations.
- It is important to detect them.
- They can be altered by changing the person's speech and behaviour.

## Coping and defence mechanisms

Observing the patient's coping and defence mechanisms is vital if we wish to help him. A

**What triggers defence mechanisms?**

- **Internal tensions:** pressure between the superego and the id.
- **Various stress factors**
- **Fear of losing face:** judgment of others; fear of violence; fear of suffering.



defence mechanism is a process or behaviour that a person uses to protect himself. Coping mechanisms help a person deal with a situation. (Margot Phaneuf, Defensive and adaptive mechanisms among cancer patients. INFIRESSOURCES, Clinic Crossroad under Psychiatric Care:

[http://www.infiressources.ca/fer/Depotdocument\\_anglais/DEFENSIVE\\_AND\\_ADAPTIVE\\_MECHANISMS\\_AMONG\\_CANCER\\_PATIENT\\_S.pdf](http://www.infiressources.ca/fer/Depotdocument_anglais/DEFENSIVE_AND_ADAPTIVE_MECHANISMS_AMONG_CANCER_PATIENT_S.pdf)

## Adaptative mechanisms

- **Affiliation:** Managing conflicts by turning to others to confide in, to ask for help or support.
- **Altruism:** Managing problems or conflicts by satisfying others' needs before our own.
- **Anticipation:** Preparing for an event by experimenting with one's thoughts and emotions before it actually occurs.
- **Avoidance:** Willingly or unwillingly turning to the unconscious or forgetting thoughts, desires, appointments and emotionally charged situations in order not to think, speak, explain or identify the source of a problem. This helps the patient avoid anxiety, fear or inconvenience. Individuals who are extremely anxious or who suffer from panic disorders often adopt avoidance when dealing with certain situations (contraphobic behaviour).
- **Humour:** Dealing with a situation by emphasizing its amusing, ridiculous or ironic aspects and putting them into perspective.
- **Sublimation:** Modifying socially unacceptable drives and transferring them to socially, personally or morally acceptable channels (prayer, devotion, etc.).
- **Suppression:** Consciously relegating to the unconscious by forgetting an idea, emotion or problem that is a source of preoccupation. Some prefer to refer to this process as putting something on the back burner (i.e. a dental appointment). (PédiaPsy : <http://membres.lycos.fr/vdc/def.htm>)
- **Coping (adaptive) mechanism**  
Coping is a complex adaptive mechanism used to deal with a difficult situation. It is sometimes important to determine whether an individual has the ability to cope with reality.

Coping consists of:

- Awareness of one's personal and outside resources;
- Realism in a given situation;
- Use of adapted problem-solving mechanisms;
- Use of coping mechanisms: disengagement, compensation, avoidance, sublimation, humour, and affiliation;
- A positive attitude in life;
- Implementation of relaxation and psychologically liberating strategies.

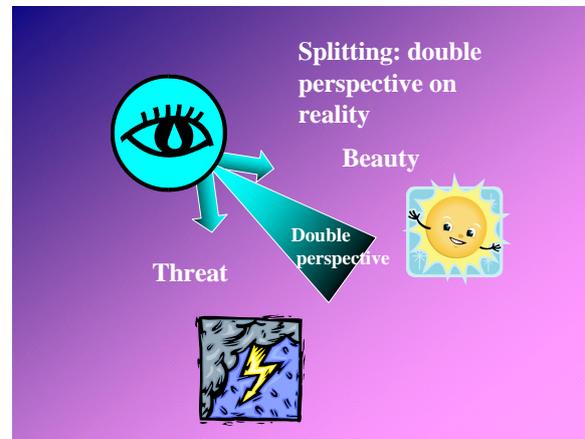
(Margot Phaneuf, Defensive and adaptive mechanisms among cancer patients, [http://www.infiressources.ca/fer/Depotdocument\\_anglais/DEFENSIVE\\_AND\\_ADAPTIVE\\_MECHANISMS\\_A\\_MONG\\_CANCER\\_PATIENTS.pdf](http://www.infiressources.ca/fer/Depotdocument_anglais/DEFENSIVE_AND_ADAPTIVE_MECHANISMS_A_MONG_CANCER_PATIENTS.pdf))

## Defence mechanisms

According to Laplanche and Pontalis, defence mechanisms consist of all operations aimed at diminishing or eliminating any change which could jeopardize the biopsychological integrity of a person. An individual implements these psychoaffective reactions or activities to protect himself from anxiety, from socially unacceptable impulses, to manage his self-image or to avoid intense suffering. Freud first defined defence mechanisms. Other authors completed the definition (i.e. Klein, Ferenczi, Anna Freud, Bergeret, Lacan).

- **Activism:** Rather than solving his problems, a person moves about restlessly.
- **Self-deprecation:** An individual will use self-deprecation to avoid his responsibilities (i.e. "I'm too stupid to...").
- **Undoing:** Reacting to a feeling of guilt, an individual will seek to undo his words or actions through flattery or positive gestures.

- **Splitting:** Controlling anguish by dividing a perception of reality into two entities or visions, reacting at once in two different and even contradictory manners. An individual will perceive at once the positive and negative sides of a situation (i.e. "He's doing better, but has trouble sleeping" or "He likes the caregiver, even though he denigrates her in front of others").



- **Compartmentalization:** Separating and opposing positive and negative affects while failing to integrate them into a coherent image. An individual might also separate elements of his thoughts and actions or act responsibly under certain circumstances and not at all under others.
- **Compensation:** Conscious or unconscious attempt to overcome genuine or perceived inferiority, to compensate emotional deprivation, to alleviate anxiety through eating, gambling, alcohol, etc.
- **Conversion:** Masking intrapsychic conflicts or socially unacceptable pulsions and expressing them symbolically in the form of physical symptoms.
- **Denial:** Unconsciously denying one's thoughts, desires, needs or aspects of reality that are deemed unacceptable.
- **Displacement:** Redirecting an idea or emotion caused by a person or situation to another person or situation (i.e. a child who is tired of being lectured by his mom kicks the cat).
- **Dissociation:** Removing oneself from the emotional significance of an idea, situation, object or relationship (i.e. person speaks dispassionately about the death of his dearly beloved mother).
- **Autistic fantasy:** Dealing with emotional problems by isolating oneself from reality and daydreaming rather than through problem solving.
- **Reaction formation:** Adopting behaviour that is contrary to one's motivations, desires and emotions (i.e. showing kindness to someone you despise).
- **Idealization:** Overestimating the positive qualities of a person or seeing only the positive aspects of a situation, usually through socially and morally elevated standards.
- **Identification:** Unconsciously adopting the characteristics of another person that is admired.
- **Stockholm syndrome (disambiguation):** The victim identifies with the aggressor. In order to quell his anguish, aggressiveness and fear, he views the aggressor in a positive light.
- **Intellectualisation:** Using abstract thinking to control or minimize emotions or disruptions.
- **Introjection:** Unconsciously assimilating the attitudes, ideas, or positive or negative desires of another person (i.e. introjecting parental values).
- **Reversed behaviour:** Expressing outwardly, through speech or behaviour, by fear, shame, guilt or sorrow, the exact opposite of what one feels (i.e. developing aggressive behaviour towards a person we have loved who is leaving us).

- **Emphasizing affects:** Especially emphasizing one's affects and using their expression excessively to avoid their rational analysis and understanding. Feelings are unconsciously magnified for defensive purposes.  
(Friard, Dominique. Les mécanismes de défense. Consulted on February 15, 2007).
- **Omnipotence:** Feeling and acting as if possessing supernatural powers or abilities that are greater than those of others and even treating them as inferiors or with disdain.
- **Projection or projective identification:** Attributing one's feelings, intentions and socially unacceptable ideas to another person.
- **Rationalization:** Modifying one's desires, emotions or socially unacceptable drives for more acceptable ones. The individual seeks logical explanations and excuses for his behaviour (i.e. "She lost her job, but that's all right because she didn't like it anyway").
- **Passive aggression:** Indirectly expressing one's aggression, unkindness or resentment towards others by causing them harm in a non-visible way.
- **Regression:** Returning to a lower development stage that is deemed more appealing and safe at the emotional level. A prolonged illness, even trivial, often leads to regression. In psychiatry, regression is clearly expressed through child-like behaviour.
- **Repression:** Seeking to erase (unconsciously) a morally or socially inexpressible thought (i.e. rape during childhood).
- **Turning against the self (self-blame):** Being unable to express one's aggressiveness towards others or having gone through all methods to express it, the individual thinks that he is guilty and turns this aggressiveness against himself. He feels anger against himself, blames himself and might even commit suicide.
- **Apathetic retreat:** Switching off from a situation or avoiding getting involved by demonstrating lack of energy or interest. Apathetic retreat can be a form of passive aggression.
- **Autistic fantasy:** Dealing with emotional problems by isolating oneself from reality and daydreaming rather than through problem resolution
- **Ritualization:** Developing a *modus operandi* which takes on a meaning of its own. Following the ritual overcomes the meaning of the action itself. It becomes predominant and even constrictive in the individual's life. This mechanism protects the individual from anxiety, but it is not always effective as he risks becoming a slave to his repetitive rituals. (Friard, Dominique. Les mécanismes de défense. Consulted on February 15, 2007).
- **Somatization or conversion:** Transferring anxiety and affects to the body and converting them into physical symptoms. Conversion is a mechanism associated with hysteria which can appear in the form of neurological symptoms such as parasthesia, paralysis and bodily transformations.

## Satisfying one's needs

It is important to understand how a person succeeds or fails to satisfy his or her own needs. For example, a violent husband may sacrifice his

Needs to be satisfied

**Needs:**

-  **Survival and reproduction**
-  **Power**
-  **Belonging**
-  **Freedom**
-  **Pleasure**
-  **Determine how a person satisfies a given need over another (i.e. sacrificing the need to belong for the need for power).**

W. Glasser (1997) Enseigner à l'école qualité. Montréal, Chenelière McGraw-Hill.

need for belonging and love in exchange for power. One can use Maslow or Virginia Henderson's tables to observe how needs are met. We herein use that of Glasser, which is easy to use and practical in psychiatry.

Glasser recognizes the needs for:

- **Survival:** physiology, health, reproduction;
- **Power:** work, money, social position, prestige, success, authority, control, violence;
- **Belonging:** love, friendship, mutual aid, solidarity, companionship;
- **Freedom:** independence, autonomy, choice, egocentricity, individualism;
- **Pleasure:** recreation, resting, leisure.

## Physical examination

In a psychiatric department, the primary concern is the patient's psychic aspects; however, we should also observe potential physical problems. The tables herein summarize factors that should be considered.

| <b>Clinical Examination (1)</b> |   |
|---------------------------------|---|
| <b>Respiratory function</b>     | Dyspnea, coughing, expectorations, pain, thoracic distortion, breathing and frequency, drawing, hemoptysis, digital hypocratism, cyanosis, speed of capillary flow.   |
| <b>Cardiac function</b>         | Precordial pain, orthopnea, dyspnea, effort intolerance, palpitations, syncope, lipothymia, fatigue, arterial tension.  |
| <b>Vascular function</b>        | Specific (Godet) or generalized edema, numbness, intermittent limping, coloration and discoloration of the skin, quality and frequency of pulse, capillary filling, dorsalis pedis pulse, poplitea, varicose veins. |
| <b>Digestive function</b>       | Nutrition, hydration, digestion, gastroesophageal reflux, nausea, vomiting, hematemesis, flatulence, icterus, pain, constipation, diarrhea, melena, colour of stools, hemorrhoids, gain or loss of weight.          |

A physical examination must cover every aspect (emphasizing problematic ones) in order for the nurse to come up with the necessary details for a therapeutic plan, regardless of the method used (i.e. gathering data, using Virginia Henderson's table or analyzing physiological systems and functions).

## Clinical examination (2)

|                              |   |
|------------------------------|---|
| <b>Mental condition</b>      | Mood, thought process, concentration, delirium, hyperactivity, withdrawal, hallucinations, suicidal thoughts.   |
| <b>Tegumentary function</b>  | Cuts, scratches, burning marks, bruises, eschar, pruritis, dry skin, dermatitis, edema, coloration-discoloration, protuberance, hair condition.   |
| <b>Neck and head</b>         | Diplopia, hazy vision, scotoma, redness, irritation, edema on eyelids, conjunctivitis, blepharitis, hematoma, lacrymation, chalazion, otalgia, external ear infection, deafness, tinnitus, otorrhea, epistaxis, rhinorrhea, neck mass, condition of teeth, prosthesis, lesions on the lips or mucous membrane of mouth, angina. |
| <b>Neurological function</b> | Current state of awareness, orientation, memory, cephalitis, vertigo, dizziness, convulsion, loss of consciousness, paresis, paresthesia, paralysis, various reflexes (Babinski, pupil), ability to speak and communicate.  |

## Clinical examination (3)

|                                |  |
|--------------------------------|--|
| <b>Locomotor function</b>      | Limited span of movements, claudication, cramps, stiffness, bone pain, muscle pain, articular pain, carpal tunnel, paralysis, amputation.  |
| <b>Genito-urinary function</b> | <p><u>Woman</u>: vaginal bleeding, dysmenorrhea, secretions, pruritus, abdominal pain, vaginal pain, vulvar soreness, excrescence, dyspareunia, pregnancy.</p> <p><u>Breasts</u>: mass, pain, breastfeeding, chafing, fissure of nipple, discharge.</p> <p><u>Man</u>: urethral discharge, lesion, scrotal hypertrophy, penile deformation, mass in the groin, impotence.</p> <p><u>Both genders</u>: dysuria, bleeding, mass or lesion, frequency of urination, characteristics of urine, incontinence, measures implemented.</p> |

### Assessing pain

In psychiatry, as in any other medical field, it is essential to observe any sign or symptom of pain, especially among patients who express signs of somatoform disorders, given the place pain occupies in their lives. The observation also ensures that the patient doesn't suffer from a genuine problem which otherwise may go undetected. There is a risk that we might become accustomed to the complaints of this type of patient and fail to take notice.

| PQRST Model |  |  |  |
|-------------|--|--|--|
|             | Notion   | Explanation  | Example  |
| P           | Provoke<br>Palliate  | What provokes the onset of the symptoms? What relieves them? | How did the pain arise? Are you using analgesics?  |
| Q           | Quality<br>Quantity  | Description of symptom, frequency.                           | What are you experiencing (approximately): burning, drumming, etc. What is your level of pain on a scale of 1 to 10? |
| R           | Region (site) affected by irradiation                              | Site of the symptom.<br>Other sites affected.                | Tell me where you are feeling uncomfortable or show me with your finger! Do you feel discomfort elsewhere?           |
| S           | Accompanying Symptoms  | Other accompanying symptoms.                                 | Is there any other discomfort accompanying this symptom?   |
| T           | Time, duration<br><br>Adapté de Mario Brulé et Lyne Cloutier, 2001 | Moment symptom appeared, duration.                           | When did the discomfort appear? Is it still present or intermittent? How many times per day or per week?             |

We should identify:

- The source of pain;
- Its intensity by using a scale that is generally accepted by professionals;
- Its frequency;
- The site and radiation of the pain;
- Manifestations and related symptoms (nausea, headaches, spasms, constipation, diarrhea);
- When the pain appeared, its duration and for how long the patient has been suffering.

Nurses should remember to consider the emotions accompanying the pain such as: indifference, anxiety, anguish or fear of death. In order to get a clear idea of the situation, one should observe the frequency of the complaints and the patient's insistence on having the caregiver acknowledge his pain.

The table above summarizes aspects that should be taken into consideration.

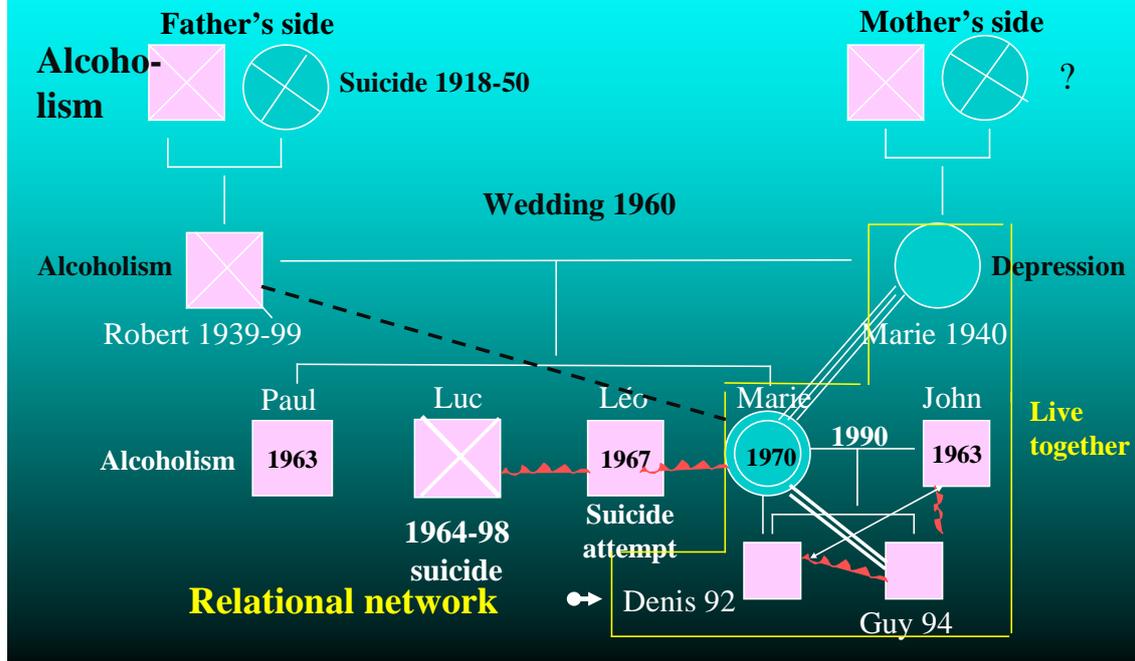
## **Milieu, family and environment**

Nurses should factor in the patient's living environment and his support network such as his family and the social workers and caregivers of his foster home. It is important to know who is taking care of the patient and who can help him if necessary.

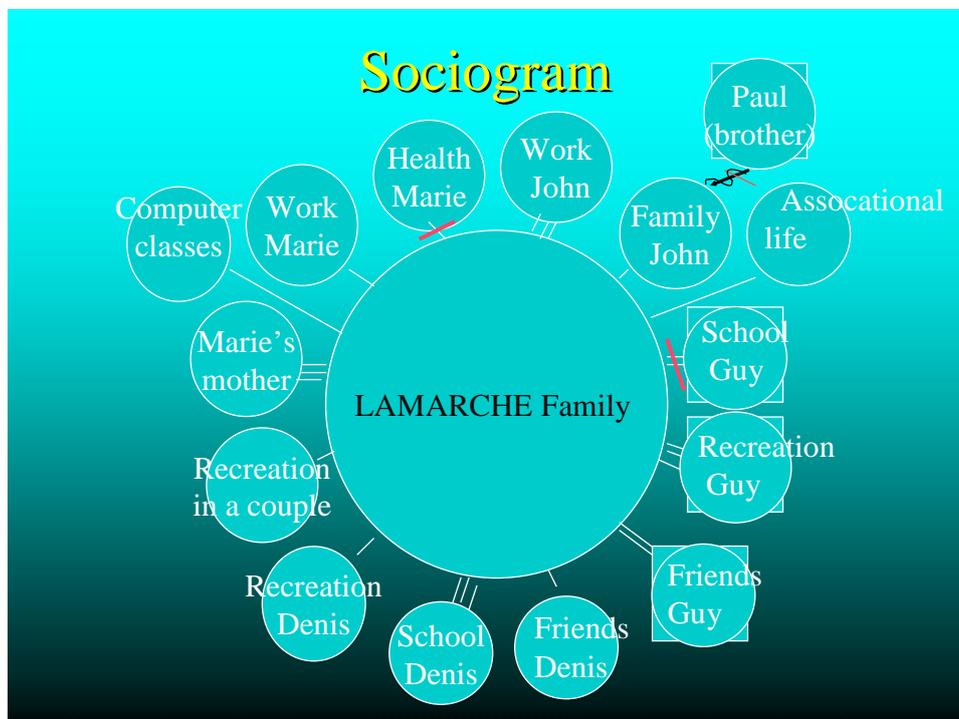
Knowledge of the patient's family history can also help us understand him and to determine how to intervene. Tools such as the genogram or the sociogram are practical in achieving this objective.

The genogram shows the family history of Marie, who is being treated for depression. It also illustrates her relations with her parents and siblings and her attachment to her immediate family.

## Genogram: Lamarche Family



## Sociogram



The sociogram is another tool which sheds light on relations with the immediate and extended family, with friends or with other outside entities such as the workplace, healthcare facilities, school and recreational activities. The sociogram herein illustrates the relations of Guy, a problem child.

## Conclusion

Psychiatric observation is composed of multiple aspects that need to be covered on a case-by-case basis. The caregiver needs to be aware that every dimension covered in her training might come in handy. That is also why there is a need to develop at once a broad and precise method to gather information to develop the patient's therapeutic plan and to apply it.

## BIBLIOGRAPHY

Brûlé, Mario et Lyne Cloutier (2001). L'examen clinique dans la pratique infirmière. Montréal, Erpi.

Bruneau-Morin, Denise (2002). Notes de cours. Cégep Saint-Jean-sur-Richelieu, Québec.

Evène, F Citation de Denis Diderot (1713-1784) <http://www.evene.fr/citations/auteur.php?ida=311&p=2>. Tiré du Dictionnaire raisonné des sciences, des arts et des métiers. Consulté le 26 janvier 2007.

Friard, Dominique. Les mécanismes de défense : [http://www.serpsy.org/formation\\_debat/defense.html](http://www.serpsy.org/formation_debat/defense.html). Consulté le 15 février 2007.

Glasser, W (1997). Enseigner à l'école qualité. Montréal, Chenelière McGraw-Hill.

La pédagogie Freinet et les pédagogies actives. L'observation à l'école Decroly <http://freinet.org/educpop/PFPA/observation.html>. Consulté le 25 janvier 2007.

Geopsy.com Psychiatrie adulte [http://www.geopsy.com/cours\\_psycho/patho\\_generale.pdf](http://www.geopsy.com/cours_psycho/patho_generale.pdf). Consulté le 28 janvier 2007.

Les mécanismes de défense. PédiaPsy : <http://membres.lycos.fr/vdc/def.htm>. Consulté le 25 février 2007.

Phaneuf, Margot (2002). Communication, entretien, relation d'aide et validation. Montréal, Chenelière/McGraw-Hill.

Phaneuf, Margot (2006). Defensive and adaptive mechanisms among cancer patients. INFIRESSOURCES, Clinic Crossroad under Psychiatric Care: [http://www.infiressources.ca/fer/Depotdocument\\_anglais/DEFENSIVE\\_AND\\_ADAPTIVE\\_MECHANISMS\\_AMONG\\_CANCER\\_PATIENTS.pdf](http://www.infiressources.ca/fer/Depotdocument_anglais/DEFENSIVE_AND_ADAPTIVE_MECHANISMS_AMONG_CANCER_PATIENTS.pdf)

Phaneuf, Margot (2007). La maladie d'Alzheimer fléau de notre temps. Montréal, Chenelière/McGraw-Hill.

Samuel-Lajeunesse, Bertrand et coll. (1998). Manuel de thérapie comportementale et cognitive. Paris, Dunod, p.190.

Senon, Jean-Louis. Conduite de l'entretien en psychiatrie. <http://www.senon-online.com/Documentation/telechargement/3cycle/Psychiatrie/des%20IR/Senon%20Conduite%20entretien%20psychiatrie.pdf>.

Wikipédia. Méthode scientifique. [http://fr.wikipedia.org/wiki/M%C3%A9thode\\_scientifique](http://fr.wikipedia.org/wiki/M%C3%A9thode_scientifique). Consulté le 25 janvier 2007.

Wikipédia. Observation <http://fr.wikipedia.org/wiki/Observation>. Consulté le 24 janvier 2007.