4.12: IV Glossary

**ADOPIE:** A mnemonic for the components of the nursing process: Assessment, Diagnosis, Outcomes Identification, Planning, Implementation, and Evaluation.

**Affect:** A client’s expression of emotion.

**Akathisia:** Motor restlessness.

**Alexithymia:** The inability to describe emotions with how one is feeling.

**Anhedonia:** The lack of experiencing pleasure in activities normally found enjoyable.

**Apathy:** A lack of feelings, emotions, interests, or concerns.

**Biological therapies:** Any form of treatment for mental health disorders that attempts to alter physiological functioning, including drug therapies, electroconvulsive therapy, and psychosurgery. [1]

**Blunted:** A diminished range and intensity of affect or mood.

**Chief complaint:** The patient’s primary reasons for seeking care.

**Circumstantial:** Speaking with many unnecessary or tedious details without getting to the point of the conversation.

**Clang associations:** Stringing words together that rhyme without logical association and do not convey rational meaning. For example, a client exhibiting clang associations may state, “Here she comes with a cat catch a rat match.”

**Clouded consciousness:** A state of reduced awareness to stimuli.
Cognition: The mental action or process of acquiring knowledge and understanding through thought, experience, and the senses. It includes thinking, knowing, remembering, judging, and problem-solving.

Cognitive impairment: Impaired mental processes that drive how an individual understands and acts in the world, affecting the acquisition of information and knowledge. Components of cognitive functioning include attention, decision-making, general knowledge, judgment, language, memory, perception, planning, and reasoning.

Coma: A state of unarousable unresponsiveness, where vigorous noxious stimuli may not elicit reflex motor responses.

Congruence: Consistency of verbal and nonverbal communication.

Countertransference: A tendency for the examiner to displace (transfer) their own feelings onto the client, and these feelings may influence the client.

Cultural humility: A humble and respectful attitude toward individuals of other cultures that pushes one to challenge their own cultural biases, realize they cannot know everything about other cultures, and approach learning about other cultures as a life-long goal and process.

Delirium: An onset of an abnormal mental state, often with fluctuating levels of consciousness, disorientation, irritability, and hallucinations. Delirium is often associated with infection, metabolic disorders, or toxins in the central nervous system.

Delusions: A fixed, false belief not held by cultural peers and persisting in the face of objective contradictory evidence. For example, a client may have the delusion that the CIA is listening to their conversations via satellites.

Development: Physical, social, and cognitive changes that occur continuously throughout one’s life.

Diagnostic and Statistical Manual of Mental Disorders (DSM-5): The manual used to make mental health diagnoses established by mental health experts.

Disheveled: A client’s hair, clothes, or hygiene appears untidy, disordered, unkempt, or messy.

Distractibility: A state when the client’s attention is easily drawn to unimportant or irrelevant external stimuli.

Dyskinesia: Uncontrolled, involuntary movements.

Dysphoric: A client’s mood or affect exhibiting persistent sadness or depression.

Euphoric: A pathologically elevated sense of well-being.

Euthymic: Normal affect and mood with a wide range of emotion appropriate for the situation.

Family dynamics: Patterns of interactions among relatives, their roles and relationships, and the various factors that shape their interactions. Because family members rely on each other for emotional, physical, and economic support, they are primary sources of relationship security or stress. Family dynamics and the quality of family relationships can have either a positive or negative impact on an individual’s health.
Flat: No emotional expression.

Flight of ideas: A state where the client frequently shifts from one topic to another with rapid speech, making it seem fragmented. The examiner may feel the client is rambling and changing topics faster than they can keep track, and they probably can’t get a word in edgewise. An example of client exhibiting a flight of ideas is, “My father sent me here. He drove me in a car. The car is yellow in color. Yellow color looks good on me.”

Grandiose delusions: A state of false attribution to the self of great ability, knowledge, importance or worth, identity, prestige, power, accomplishment. Clients may withdraw into an inner fantasy world that’s not equivalent to reality, where they have inflated importance, powers, or a specialness that is opposite of what their actual life is like.

Hallucinations: False sensory perceptions not associated with real external stimuli that can include any of the five senses (auditory, visual, gustatory, olfactory and tactile). For example, a client may see spiders climbing on the wall or hear voices telling them to do things. These are referred to as “visual hallucinations” or “auditory hallucinations.”

Homicidal ideation: Threats or acts of life-threatening harm towards another person.

Illusions: Misperceptions of real stimuli. For example, a client may misperceive tree branches blowing in the wind at night to be the arms of monsters trying to grab them.

Inclusiveness: The practice of providing equal access to opportunities and resources for people who might otherwise be excluded or marginalized, such as those having physical or mental disabilities or belonging to other minority groups.

Insight: The client demonstrates awareness of their situation.

Integrative therapies: Psychotherapy that selects theoretical models or techniques from various therapeutic schools to suit the client’s particular problems.

Intellectual disability: A diagnostic term that describes intellectual and adaptive functioning deficits identified during the developmental period prior to the age 18.

Labile: Rapid changes in emotional responses, mood, or affect that are inappropriate for the moment or the situation.

Loose associations: Jumping from one idea to an unrelated idea in the same sentence. For example, the client might state, “I like to dance; my feet are wet.” The term “word salad” refers to severely disorganized and virtually incomprehensible speech or writing, marked by severe loosening of associations.

Maslow’s Hierarchy of Needs: A theory commonly used to prioritize the most urgent patient needs.

Mental status examination: An assessment of a client’s level of consciousness and orientation, appearance and general behavior, speech, motor activity, affect and mood, thought and perception, attitude and insight, and cognitive abilities.
Milieu therapy: Nursing interventions used to assist health care consumers to make positive change and promote recovery by creating a therapeutic milieu. Milieu therapy includes interventions such as providing empathy, assisting in problem-solving, acting as a role model, demonstrating leadership, confronting discrepancies, encouraging self-efficacy, decreasing stimuli when necessary, and manipulating the environment so that the above interventions can be effective.¹¹

Mood: The predominant emotion expressed by an individual.¹²

Non-suicidal self-injury (NSSI): Intentional self-inflicted destruction of body tissue without suicidal intention and for purposes not socially sanctioned. Common forms of NSSI include behaviors such as cutting, burning, scratching, and self-hitting.

Nursing diagnosis: A clinical judgment concerning a human response to health conditions/life processes or a vulnerability for that response, by an individual, family, group, or community.

Nursing process: A critical thinking model based on a systematic approach to patient-centered care. Nurses use the nursing process to perform clinical reasoning and make clinical judgments when providing patient care.

Obsessions: Persistent thoughts, ideas, images, or impulses that are experienced as intrusive or inappropriate and result in anxiety, distress, or discomfort. Common obsessions include repeated thoughts about contamination, a need to have things in a particular order or sequence, repeated doubts, aggressive impulses, and sexual imagery. Obsessions are distinguished from excessive worries about everyday occurrences because they are not concerned with real-life problems.¹³

Obtundation: A moderate reduction in the client’s level of awareness so that mild to moderate stimuli do not awaken the client. When arousal does occur, the patient is slow to respond.

Outcome: A measurable behavior demonstrated by the patient who is responsive to nursing interventions.

Paranoia: A condition characterized by delusions of persecution.¹⁴ Clients often experience extreme suspiciousness, mistrust, or expression of fear. For example, a resident of a long-term care facility may have delusions that the staff is trying to poison him.

Poverty of content: A conversation in which the client talks without stating anything related to the question, or their speech in general is vague and meaningless.

Prioritization: The process of identifying the most significant problems and the most important interventions to implement based on a client’s current status.

Psychiatric-mental health nursing: The nursing practice specialty committed to promoting mental health through the assessment, diagnosis, and treatment of behavioral problems, mental disorders, and comorbid conditions across the life span. Psychiatric-mental health nursing intervention is an art and a science, employing a purposeful use of self and a wide range of nursing, psychosocial, and neurobiological evidence to produce effective outcomes.¹⁵
Psychomotor agitation: A condition of purposeless, non-goal-directed activity.

Psychomotor retardation: A condition of extremely slow physical movements, slumped posture, or slow speech patterns.

Psychosocial assessment: A component of the nursing assessment process that obtains additional subjective data to detect risks and identify treatment opportunities and resources.

Psychotherapy interventions: Generally accepted and evidence-based methods of brief or long-term therapy, including individual therapy, group therapy, marital or couple therapy, and family therapy. These interventions use a range of therapy models including, but not limited to, psychodynamic, cognitive, behavioral, and supportive interpersonal therapies to promote insight, produce behavioral change, maintain function, and promote recovery.

Racing thoughts: Fast-moving and often repetitive thought patterns that can be overwhelming. They may focus on a single topic, or they may represent multiple different lines of thought. For example, a client may have racing thoughts about a financial issue or an embarrassing moment.

Resilience: The ability to overcome serious hardship or traumatic experiences.

Rumination: Obsessional thinking involving excessive, repetitive thoughts that interfere with other forms of mental activity.

Safety plan: A prioritized written list of coping strategies and sources of support that clients can use before or during a suicidal crisis. The plan should be brief, in the client’s own words, and easy to read. After the plan is developed, the nurse should problem solve with the client to identify barriers or obstacles to using the plan. It should be discussed where the client will keep the safety plan and how it will be located during a crisis.

SMART outcomes: Outcome statements should contain five components easily remembered using the “SMART” mnemonic: Specific, Measurable, Attainable/Action-oriented, Relevant/Realistic, with a Time frame.

Spirituality: A sense of connection to something larger than oneself that typically involves a search for meaning and purpose in life.

Stupor: A state of unresponsiveness unless a vigorous stimulus is applied, such as a sternal rub. The client quickly drifts back into a deep sleep-like state on cessation of the stimulation.

Suicide attempt: An action in which there is intent to end one’s life but the individual does not die as a result of their actions.

Suicidal ideation: When an individual has been thinking about suicide but does not necessarily have an intention to act on that idea.

Suicide plan: An individual who has a plan for suicide, has the means to injury oneself, and has the intent to die.

Therapeutic milieu: A safe, welcoming, supportive, and functional physical treatment environment.
**Transference:** When the client projects (i.e., transfers) their feelings to the nurse. For example, a client is feeling angry at a family member related to a previous disagreement and displaces the anger to the nurse during the interview.