11.4: Applying the Nursing Process to Schizophrenia

Now that we have discussed the symptoms and treatments for psychosis and schizophrenia, we will explain how to apply the nursing process to a client experiencing an acute psychotic episode related to schizophrenia.

**Assessment**

Assessment includes interviewing the client, observing verbal and nonverbal behaviors, and completing a mental status examination and a psychosocial assessment. Common findings during a mental status examination for a client with schizophrenia experiencing an acute psychotic episode are described in Table 11.4a. Review information about performing a mental status examination and psychosocial assessment in the “Application of the Nursing Process in Mental Health Care” chapter. It is also important to assess for suicide risk for clients with psychosis. Review how to assess for suicide risk in the “Foundational Mental Health Concepts” chapter.

Table 11.4a Common Findings During a Mental Status Examination for Individual With Schizophrenia Experiencing an Acute-Psychotic Episode

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Common Findings During Psychotic Episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Consciousness and Orientation</td>
<td>(*Indicates immediately the notify health care provider)</td>
</tr>
<tr>
<td>• Unable to provide name, location, or day</td>
<td></td>
</tr>
<tr>
<td>• Clouded consciousness</td>
<td></td>
</tr>
</tbody>
</table>
Appearance and General Behavior

- Unkempt or poor hygiene
- Not dressed appropriately for the weather and/or situation
- Does not socialize with others
- May demonstrate threatening behavior
- Shows negativism (a tendency to resist or oppose requests of others)
- Has impaired impulse control (which can increase the risk of assault)
- Exhibits boundary impairment, an impaired ability to sense where one’s influence ends and another person’s begins (e.g., the person might walk up to a table and drink out of someone else’s glass)

Speech

- Does not respond to verbal questions
- Does not appropriately follow instructions (based on development level)
- Exhibits alogia (reduction or poverty in speech), rapid or pressured speech, or halting speech

Motor Activity

- Catatonia (a pronounced increase or decrease in the rate and amount of movement, where excessive movement is purposeless)
- Motor retardation (a pronounced slowness of movement)
- Motor agitation (running or pacing rapidly in response to internal or external stimuli)
- Echopraxia (mimicking movements of another person)

Affect and Mood

- Flat, blunted, constricted, or labile affect
- Inappropriate or incongruent with the situation
- Anhedonia (reduced ability to experience pleasure)
- Avolition (reduced motivation or goal-directed behavior)
- Asociality (decreased desire for social interaction)
- Apathy (decreased interest in activities that would otherwise be interesting)

Thought and Perception

- Hallucinations (false sensory perceptions not associated with real external stimuli that can include any of the five senses such as visual, auditory, tactile, gustatory, or olfactory)
- Delusions (a fixed, false belief not held by cultural peers and persisting in the face of objective contradictory evidence)
- Illusions (misperceptions of real stimuli)
- Disorganized or bizarre thoughts
• Flight of ideas
• **Loose associations** (jumping from one idea to an unrelated idea in the same sentence)
• Clang associations
• **Echolalia** (pathological repetition of another person’s words)
• **Magical thinking** (falsely believing that reality can be changed simply by one’s thoughts)
• **Paranoia** (an irrational fear ranging from being suspicious to thinking someone is trying to kill you)
• *Suicidal or homicidal ideation that can result from command hallucinations or defensive actions in response to paranoia*

**Attitude and Insight**
• **Anosognosia** (the inability to recognize that one is ill)

**Cognitive Abilities**
• Concrete thinking (impaired ability to think abstractly)
• Short-term memory impairment
• Impaired information processing
• Impaired reasoning

**Examiner’s Reaction to Client**
• Frustration
• Anxiousness
• Countertransference

When assessing hallucinations, do not imply the perceptions are real. For example, a nurse should ask the client, “What do you hear?” not “What are the voices saying?” It is important to assess for command hallucinations, such as, “Are you hearing a voice that is telling you to do something,” followed by, “Do you believe what you hear is real?” If the answer is “Yes,” the client is at increased risk for acting on the command. Assess when the hallucinations began, their content, and the manner in which the client experiences them (i.e., Are they supportive or distressing? In the background or intrusive?). Ask what makes them worse or better, how the client responds, and what they do to cope with the hallucinations.  

When assessing delusions, determine if the client is capable of reality testing (i.e., questioning their thoughts and determining what is real). Ask the client if they believe there is any danger related to the delusion.  

Assess the client’s ability to perform activities of daily living. Are they getting adequate food, fluid, sleep, and rest? Are they completing daily hygiene tasks and dressing safely for weather conditions? Are they able to control their impulses and make safe decisions?
Determine if the client is taking their medications as prescribed, their effectiveness, and if they are experiencing side effects. Are there any barriers to medications or other treatment, such as cost, stigma, or mistrust of health care providers?\(^5\)

Nurses also assess for adverse effects of medications, such as involuntary movements associated with the use of antipsychotic medications (e.g., extrapyramidal side effects or tardive dyskinesia). Clients are routinely assessed for these adverse effects using scales like the Abnormal Involuntary Movement Scale.

View a YouTube video\(^6\) of a nurse performing an assessment using an Abnormal Involuntary Movement Scale: [Mental Health AIMS Assessment](#)

When possible, assess family members and significant others’ knowledge of the client’s illness and their response. Are they overprotective, frustrated, or anxious? Are they familiar with family support groups, respite, and other community resources?\(^7\)

**Diagnostic and Lab Work**

Ensure the client has had a medical workup for other potential causes of psychosis. For example, dehydration, infection, electrolyte imbalances, abnormal blood glucose level, substance use, or withdrawal from substances can cause psychosis. Concurrent medical disorders are common and should be treated in addition to treating schizophrenia.

If the client is currently taking psychotropic medications, therapeutic drug levels of some types of medications are required. As always, review current information from a medication reference before administering medications.

**Diagnoses**

Mental health disorders like schizophrenia are diagnosed by mental health providers using the *DSM-5*. Nurses create individualized nursing care plans based on the client’s responses to their mental health disorders. See Table 11.4b for a list of common nursing diagnoses and human responses related to schizophrenia.

**Table 11.4b Common Nursing Diagnoses Related to Schizophrenia**\(^8\)\(^9\)

<table>
<thead>
<tr>
<th>Nursing Diagnosis</th>
<th>Definition</th>
<th>Selected Defining Characteristics</th>
</tr>
</thead>
</table>
| **Risk for Suicide** | Susceptible to self-inflicted, life-threatening injury. | • Reports desire to die  
• Threats of killing self  
• Hopelessness  
• Social isolation |
Ineffective Coping
A pattern of invalid appraisal of stressors, with cognitive and/or behavioral efforts, that fails to manage demands related to well-being.

• Alteration in concentration
• Alteration in sleep pattern
• Inability to meet basic needs
• Ineffective coping strategies
• Insufficient goal-directed behavior
• Risk-taking behavior

Self-Neglect
A constellation of culturally framed behaviors involving one or more self-care activities in which there is a failure to maintain a socially accepted standard of health and well-being.

• Insufficient personal hygiene
• Insufficient environmental hygiene
• Nonadherence to health activity

Impaired Communication
Decreased, delayed, or absent ability to receive, process, transmit, and/or use a system of symbols.

• Inappropriate verbalizations
• Difficulty comprehending communication
• Difficulty expressing thoughts verbally

Imbalanced Nutrition: Less than Body Requirements
Intake of nutrients insufficient to meet metabolic needs.

• Food intake less than recommended daily allowance
• Insufficient interest in food
• Body weight 20% or more below ideal weight range
• Read more in the “Nutrition” chapter in Open RN Nursing Fundamentals
Sleep Deprivation  
Prolonged periods of time without sustained natural, periodic suspension of relative consciousness that provides rest.

Social Isolation  
Aloneness experienced by the individual and perceived as imposed by others and as a negative or threatening state.

Hopelessness  
Subjective state in which an individual sees limited or no alternatives or personal choices available and is unable to mobilize energy on own behalf.

Spiritual Distress  
A state of suffering related to the impaired ability to experience meaning in life through connections with self, others, the world, or a superior being.

Readiness for Enhanced Hope  
A pattern of expectations and desires for mobilizing energy on one’s own behalf, which can be strengthened.

- Anxiety
- Agitation
- Transient paranoia
- Intrusive thoughts
- Read more in the “Sleep and Rest” chapter of Open RN Nursing Fundamentals
- Impaired communication patterns
- Disturbed thought processes
- Delusional thinking
- Long-term stress from mental illness
- Ineffective coping strategies
- Perceived insufficient meaning in life
- Hopelessness
- Social alienation
- Expresses desire to enhance connectedness with others
- Expresses desires to enhance sense of meaning in life

Outcome Identification

Outcomes should be consistent with the recovery model and emphasize hope, resilience, living a full and productive life,
and recovery from illness. Expected outcomes are identified based on the client’s current phase of their illness: acute, stabilization, or maintenance:

- **Acute**: The overall goal in the acute phase of schizophrenia is patient safety and stabilization. An example of an expected outcome is, “The client will consistently be able to label their hallucinations as ‘not real’ and a symptom of their illness by discharge.”

- **Stabilization**: Goals during the stabilization phase focus on understanding the illness and the prescribed treatment plan, as well as controlling and/or coping with symptoms using an optimal medication and psychosocial treatment regimen. Outcomes typically target negative and cognitive symptoms of schizophrenia during this phase because these symptoms respond less well to initial medication treatment than do positive symptoms. An example of an expected outcome during the stabilization phase is, “The client will establish two goal-directed activities by the end of the shift.”

- **Maintenance**: Goals during the maintenance phase focus on maintaining and increasing symptom control and optimal functioning. Factors include treatment adherence, increasing independence, and a satisfactory quality of life. An example of an expected outcome during the maintenance phase is, “The client will identify advantages for taking medications by the end of Week 2.”

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### Planning Interventions

Hospitalization is indicated during the acute phase of schizophrenia if the client is considered a danger to self (e.g., refuses to eat or is too disorganized to function in the community) or to others (e.g., is behaving in a threatening manner to others).

During the stabilization and maintenance phases, planning focuses on education, support, and skills training for the client and family. It also addresses how and where these needs can be met within the community. As explained previously in this chapter, relapse prevention efforts are vital. Each relapse can increase residual dysfunction and deterioration and can contribute to despair, hopelessness, and suicide risk. Additionally, recognizing early signs of relapse (e.g., reduced sleep, social withdrawal, and worsening concentration) and implementing intensive treatment are needed to minimize the disruption of the client’s life.

---

### Implementation

During the acute phase of schizophrenia, hospitalization provides safety, structure, and support. As discussed earlier, anosognosia may impair the client’s ability to recognize their mental illness. In this case, court-ordered hospitalization may be required. Read more about court-ordered hospitalization in the “Legal and Ethical Considerations in Mental Health Care” chapter. Nursing interventions focus on providing safety, promoting hygiene and nutrition, improving socialization, encouraging hope and self-esteem, preventing falls, using specific therapeutic techniques, addressing physiological needs, and implementing collaborative interventions.
Provide Safety

Clients with command hallucinations require close monitoring for suicide, homicide, and other violence risk. Implement interventions to reduce risk of suicide as described in the "Application of the Nursing Process in Mental Health Care" chapter.

Interpersonal conflict, paranoia, delusions, impaired judgment, limited impulse control, fear, and disagreement with unit rules increase the risk for aggressive behavior. Nursing interventions addressing increased risk for violence to self and others are described in the following box. Read more about recognizing signs of crisis and crisis interventions in the "Stress, Coping, and Crisis Intervention" chapter.

Nursing Interventions Addressing Risk for Violence [18]

- Assess for suicide risk and increase supervision when risk is present. Make rounds at unpredictable intervals and adjust frequency based on risk. Read more about assessing suicide risk in the "Foundational Mental Health Concepts" chapter and interventions for risk of suicide in the "Application of the Nursing Process in Mental Health Care" chapter.
- Assess for paranoid thoughts, command hallucinations, impaired impulse control, interpersonal conflict, increasing tension and desperation, and other factors that increase the risk of violence.
- Establish trust and rapport. Engage regularly with the client. Promote communication in a safe manner regarding their concerns that contribute to risk of violence. Engender goodwill and a strong nurse-client relationship.
- Take actions to ensure the client feels safe and secure.
- Teach coping skills to reduce stressors.
- Provide constructive diversion and outlets for physical energy.
- Ensure clients are taking their medications as prescribed. Consider requesting long-acting injectable medications as indicated.
- If the client targets specific peers or staff, relocate individuals as needed.
- Search client belongings thoroughly on admission and repeat the search whenever circumstances suggest the client may have made or acquired a weapon.
- Use seclusion or restraints when other alternatives have not been successful in keeping the client or others safe.

Promote Hygiene and Nutrition

Promote hygiene in clients experiencing psychosis by concisely and explicitly stating expected hygiene tasks. Break tasks into smaller, more manageable tasks and assist when needed. Use visual cues to prompt hygiene tasks, such as putting clean clothes on the bed or clean towels and a toothbrush in the bathroom. Share potential benefits of improved hygiene such as improved socialization with others. Reinforce progress in performing hygiene with verbal praise or concrete rewards like additional privileges on the unit.[19]

Clients who are experiencing catatonia require assistance with nutrition, as well as other activities of daily living.
Improve Socialization

Regularly engage with the client. Initially interact briefly about low-anxiety topics like the weather and gradually increase the duration and frequency of interactions as they become more comfortable. Encourage clients to participate in unit activities without pressure, such as “We would like to see you at the morning meeting.” Reinforce the client’s control in their choices, such as, “If you become uncomfortable in the group, you can leave and try again on another day.” Provide positive reinforcement for attempts at socialization, such as, “It was nice to see you in the morning meeting today.”

Encourage Hope and Self-Esteem

Convey unconditional acceptance, empathy, and support. For example, say, “Sometimes it can feel very discouraging when experiencing a mental health disorder. I am wondering how you are feeling?” If the client cannot identify their feelings, suggest words that may apply, such as, “Sometimes it is hard to say what you are feeling. Do you feel sad, frustrated, or anxious?” Validate the client’s feelings and assure them they are not alone. Help the client identify their positive traits or previous accomplishments. Suggest coping strategies such as journaling and attending a support group. Teach stress management techniques and coping strategies as outlined in the “Stress, Coping, and Crisis Intervention” chapter.

Prevent Falls

Fall risk may be increased due to orthostatic hypotension, impaired balance, bradykinesia, or other movement disorders. Assess the client’s gait and for orthostatic hypotension. Teach the client to slowly change position from lying to sitting to standing and encourage the use of handrails or seeking assistance when feeling unsteady. Implement additional fall precautions as needed according to agency policy.

Use Therapeutic Techniques for Delusions and Hallucinations

Recall that clients with schizophrenia may have memory and attention impairments. Repetition with visual and verbal reminders is helpful to promote task completion. Additionally, short but frequent interactions may be less stimulating to the client and better tolerated. Additional techniques for helping clients who are experiencing delusions and hallucinations are described below.

Helping Clients Who Are Experiencing Delusions

Delusions feel very real to the client and can be frightening. Nurses should acknowledge and accept the client’s experience and feelings resulting from the delusion while conveying empathy. They can provide reassurance regarding their intentions to help the client feel safer.

Avoid questioning the delusion. Until the client’s ability to test reality improves, trying to prove the delusion is incorrect can intensify it and cause the client to view the staff as people who cannot be trusted. Instead, focus on the fear and what would help the client feel safer. For example, if a client states, “The doctor is here. He wants to kill me,” the nurse
could respond, “Yes, the doctor is here and wants to see you. They talk with all of the patients about their treatment. Would you feel more comfortable if I stayed with you during your meeting with the doctor?” Focusing of events in the present keeps the client focused on reality and helps them distinguish what is real. [22]

If a client is exhibiting paranoia and is highly suspicious, it is helpful to maintain consistent staff assignments. Staff should avoid laughing, whispering, or talking quietly where the client can see these actions but cannot hear what is being said. Staff should ask permission before touching the client, such as before taking their blood pressure.

Read additional strategies for working with clients with delusions from the British Columbia Schizophrenia Society: [Steps for Working With Delusions](https://med.libretexts.org/Bookshelves/Nursing/Nursing%3A_Mental_Health_and_Community_Concepts_(OpenRN)/11%3A_…)

### Helping Clients Who Are Experiencing Hallucinations

Hallucinations feel very real to the person experiencing them and can be distracting during their interactions with others. Hallucinations can be supportive or terrifying, faint or loud, or episodic or constant. For example, listen to simulations of auditory hallucinations in the following box. The nurse should focus on understanding the client’s experiences and responses and convey empathy. Command hallucinations, suicidal ideation, or homicidal ideation requires safety measures as previously discussed in the “Provide Safety” subsection.

#### Simulations of Auditory Hallucinations

British Columbia Schizophrenia Society created music tracks simulating what auditory hallucinations can feel like to clients. Similar to auditory hallucinations experienced by people living with schizophrenia, when people listen to these songs, they hear voices that can be frightening. Listen to these simulations on YouTube with discretion because some people can find them disturbing:

- **Track 05: Mark Pelli – Everything (Songs of schizophrenia mix)** [23]
- **Track 06: Cassandra Vasik – Sadly mistaken (Songs of schizophrenia mix)** [24]

When working with a client who has a history of hallucinations, watch for hallucination indicators, such as eyes tracking an unheard speaker, muttering or talking to oneself, appearing distracted, suddenly stopping a conversation as if interrupted, or intently watching a vacant area of the room. Ask about the content of the hallucinations and if they are experiencing command hallucinations. Assess how the client is reacting to the hallucinations, especially if they are exhibiting anxiety, fear, or distress. [25]

Avoid referring to the hallucinations as if they were real to promote reality testing. For example, do not ask, “What are the voices saying to you,” but instead ask, “You look as though you are hearing something. What do you hear?” Do not try to convince the client the hallucinations are not real, but instead offer your perception and convey empathy. For example, “I don’t hear angry voices that you hear, but that must be very frightening for you.” Address any underlying emotion, need, or theme indicated by the hallucination. [26]

Focus on reality-based activities in the “here and now,” such as a conversation or simple project. Promote and guide reality testing. For example, guide the client to look around the room and see if others are frightened; if they are not,
encourage them to consider what they are experiencing are hallucinations. Teach the client to compare their perceptions to trusted others. [27]

See the information in the following box for teaching clients how to manage their hallucinations.

Patient Education: Teaching Clients How to Manage Hallucinations [28]

- Manage stress and stimulation.
  - Avoid overly loud or stressful places or activities.
  - Avoid negative or overly critical people and seek out supportive people.
  - Use assertive communication skills so you can tell others “No” if they pressure or upset you.
  - When stressed, focus on your breathing and slow it down. Inhale slowly through your nose as you count from one to four, hold your breath, and then exhale slowly through your mouth.
  - Refer to other stress management and coping strategies in the “Stress, Coping, and Crisis Intervention” chapter.
- Use other sounds to compete with the hallucinations, such as talking with other people, listening to music or TV, reading aloud, singing, whistling, or humming.
- Determine what is real and unreal by looking at others. Do they seem to be hearing or seeing what you are? Ask trusted others if they are experiencing the same things you are. If the answers to these questions are “No,” then although it feels real, it is not likely real and can be ignored.
- Engage in activities that can take your mind off the hallucinations, such as walking, taking a relaxing bath or shower, or going to a place you find enjoyable where others are present, such as a coffee shop, mall, or library.
- Talk out loud (or silently to yourself if others are nearby) and tell the voices or thoughts to go away. Tell yourself the voices or thoughts are a symptom and not real. Tell yourself that no matter what you hear, you are safe and can ignore what you hear.
- Seek contact with others. Visit a trusted friend or family member. Call a help line or go to a drop-in center. Visit a public place where you feel comfortable.
- Develop a plan with your provider for how to cope with hallucinations. Additional medications may be prescribed to use as needed.

Address Physiological Needs

The client may also be experiencing physiological problems related to nutritional status, sleep, and elimination due to their symptoms of psychosis. Review nursing interventions to address these physiological needs in the “Bipolar Disorders” chapter.

Implement Collaborative Interventions

See the “Treatment” subsection of this chapter for medications and therapies prescribed for clients with psychosis. Nurses often assist in implementing these collaborative interventions.
Categorizing Nursing Interventions According to the APNA Standard of Implementation

Interventions for clients experiencing psychosis previously discussed in this chapter can also be categorized by the standard of *Implementation* by the American Psychiatric Nursing Association (APNA). Read more about this standard in the "Application of the Nursing Process in Mental Health Care" chapter. See Table 11.4c for categorization of nursing interventions by this standard.

Table 11.4c Nursing Interventions Based on the Categories of the APNA Implementation Standard

<table>
<thead>
<tr>
<th>Categories of Interventions Based on the APNA Standard of Implementation</th>
<th>What the nurse will do..</th>
<th>Rationale</th>
</tr>
</thead>
</table>

[29]
Coordination of Care

Maintain safety by implementing safety precautions as needed to prevent self-harm, suicide, or homicide risks.

Ensure consistency of behavioral expectations among all staff on the unit by including expectations in the nursing care plan.

Plan for quality of life, independence, and optimal recovery by referring to local resources and support groups in the community on discharge.

The client may exhibit high risk for impulsive behaviors that could pose a risk of harm to self/others. They may experience altered thought processes with poor insight and judgment.

Consistent expectations provide a feeling of structure and safety.

The nurse coordinates care delivery during inpatient care, as well as for after discharge.

Health Teaching

Create, adapt, and deliver health teaching to clients, including stress management, coping strategies, and management of delusions and hallucinations.

Deliver patient education about antipsychotics and expected time frames for improvement.

Open all medications in front of the client.

Observe for and promptly report symptoms of potential adverse effects of first-generation antipsychotics such as tardive dyskinesia (TD) and extrapyramidal side effects (EPS).

Nurses encourage resilience by promoting adaptive coping strategies.

The client’s understanding of their medications and potential side effects can increase medication compliance.

Opening all medications in front of the client may decrease paranoia.

Clients experiencing TD or new EPS symptoms should discontinue first-generation antipsychotics and start second-generation antipsychotics per provider order. Medications to treat symptoms may be required.
Milieu Therapy

Manage the milieu by reducing environmental stimuli and excess noise. The client may require a private room.

Promote physical exercise to redirect aggressive behavior.

During acute psychosis with agitation, use prescribed medications, seclusion, or restraint to minimize physical harm.

Encourage participation in group therapy addressing social skills, personal grooming, mindfulness, and stress management. Avoid competitive activities or games if the client is agitated.

Reducing stimuli may prevent escalation of anxiety and agitation.

Physical exercise can decrease tension and provide focus.

The nurse’s priority is to protect the patient and others from harm.

Group therapy can encourage effective coping skills and socialization. Structured activities provide security and focus. However, avoid competitive activities because they may be too stimulating and can cause escalation of anxiety and agitation.
Therapeutic Relationship and Counseling

Use a firm and calm approach with short and concise statements. For example, “John, come with me. Eat this sandwich.”

Identify expectations in simple, concrete terms with consequences. For example, “John, do not yell at or hit Peter. If you cannot control yourself, the seclusion room will help you feel less out of control and prevent harm to yourself and others.”

Acknowledge feelings associated with delusions and hallucinations and convey empathy. Encourage and guide reality testing based on client status.

Redirect excessive energy into appropriate and constructive channels.

Set limits with personal boundaries.

Structure and control improve feelings of security for a client who is feeling out of control.

Clear expectations help the patient experience outside controls and understand reasons for medication, seclusion, or restraints if they are not able to control their behaviors.

Acknowledging emotion and conveying empathy build trust and a strong nurse-client relationship. Reality testing helps clients manage their delusions and hallucinations.

Distraction and activity can be used to manage excessive movement.

Clients may be impulsive and hyperverbal and interrupt, blame, ridicule, or manipulate others.

Evaluation

A client’s progress is continually assessed using their individualized SMART outcomes and current status. Full recovery can take months. By setting small goals, it is easier to identify and recognize progress that may occur in small increments. [30]


https://med.libretexts.org/Bookshelves/Nursing/Nursing%3A_Mental_Health_and_Community_Concepts_(OpenRN)/11%3A_…

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23. BC Schizophrenia. (2019, May 6). Track 05: Mark Pelli - Everything (Songs of schizophrenia mix) [Video]. YouTube. All rights reserved. https://youtu.be/pN-f6AEDNxY.

24. BC Schizophrenia. (2019, May 6). Track 06: Cassandra Vasik - Sadly mistaken (Songs of schizophrenia mix) [Video]. YouTube. All rights reserved. https://youtu.be/HCeWO3BL1gA.

25. BC Schizophrenia. (2019, May 6). Track 05: Mark Pelli - Everything (Songs of schizophrenia mix) [Video]. YouTube. All rights reserved. https://youtu.be/pN-f6AEDNxY.


