

Communicating with Psychiatric Patients in Nursing Homes

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Today, approximately one fourth of newly admitted nursing home (NH) or assisted living residents have a psychiatric illness, with 2–3% having a diagnosis of schizophrenia or bipolar disorder (Fullerton et al., 2009). Because treating psychiatric illness is not the focus of most NHs, and because increased psychiatric admissions are a relatively new phenomenon, NH caregivers are often unprepared to care for primarily psychiatric residents (PPRs; Li, 2010). This places NHPPRs at risk for substandard care and NH caregivers at risk for burnout.

The increased care of psychiatric clients in NHs is an unintended consequence of “deinstitutionalization,” formalized by the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963. Well-intentioned regulations of the late 1950s and early 1960s, drafted after the insane asylum era and the invention of antipsychotics, emphasized an ethic of autonomy for psychiatric clients. Prior to this legislation, psychiatric clients with severe mental illness (SMI) were likely to be institutionalized for life. The new legislation encouraged care of such patients in outpatient community mental health centers instead, which at that time were a new type of facility. With federal funding going toward the new outpatient centers, most long-stay hospitals or asylums then accommodated only the acutely psychiatrically ill (Novella, 2010).

Over the decades, it has become increasingly obvious that community mental health centers have not been able to meet the needs of the chronically ill psychiatric patient. As a result, many chronically ill psychiatric patients for whom it is difficult to live independently have entered NHs. Technically, an NH does at least offer a less restrictive environment than a locked psychiatric facility. This trend continues to gather momentum today.

Quality of care for NHPPRs

In recent years, NHs have also worked to improve quality of life for their residents. The Federal NH Reform Act (1987a, 1987b, 1987c) and similar legislation were passed to address depression and mental health needs of NH residents (Spanko, 2019). One outcome of this legislation was to begin training NH caregivers on strategies for therapeutic communication, particularly in the care of dementia patients with neuropsychiatric symptoms. Despite this training, however, NHPPRs are reported to have poorer quality of care than other NH residents according to measures of pain assessment and treatment, as well as rates of completed advanced directives (Cai et al., 2011). Thus, training for communication strategies specific to the NHPPR should improve the quality of care for these residents.

Even though many NH caregivers are trained in communicating with patients with dementia, most NH caregivers are not trained specifically in psychiatry and may lack the knowledge to provide the person-centered, recovery-oriented care that can be found in many psychiatric hospitals (Grabowski et al., 2010). NH caregivers, who spend on average 4 hours a day in direct contact with NH residents (PHInational.org, 2018), will likely experience more job satisfaction if they enjoy better rapport with NHPPRs.

A final point about quality of care is related to differences in ambience between current psychiatric facilities and NHs. Despite their increased freedom as an unlocked facility, NHs remain highly supervised and have more of a medical, end-of life feel than most psychiatric facilities, which over the years, to combat stigma, have tried to downplay the hospital feeling and focus on recovery (O'Hagan, 2002). Therefore, when psychiatric patients reside in an NH, they may experience what seems a lower standard of living than what they are used to.

Nursing home caregiver communication training

The main diagnoses leading to an NH admission are dementia and post stroke syndromes, with dementia by far the most common neurological disease in NH patients (Van Rensbergen & Nawrot, 2010). Among 209 people with dementia living in long-term care facilities, 79% had one or more clinically significant neuropsychiatric symptoms, such as delusions, hallucinations, aggression, depression, apathy, mania, anxiety, irritability, and psychomotor agitation or retardation. These symptoms can occur many months before neurological diagnosis (Goodman et al., 2017; Plassman et al., 2007). Here, the term *dementia* will be used to refer to any of the dementing neurological diseases of old age, such as Alzheimer's and other dementias, post stroke syndromes, and late-stage Huntington's chorea and encephalopathies.

The basic communication strategies that most NH caregivers are trained in, by and large, can be therapeutic for many NHPPRs. For example, the most common psychiatric symptoms among the many NH residents with dementia are depression, anxiety, and difficult personality traits. Most NH caregivers have already been trained on communicating therapeutically with any patient who is exhibiting these symptoms, regardless of the patient's diagnosis. The Alzheimer's Association (2020) provides the following list of basic communication skills for use with patients in the middle stage of Alzheimer's disease, which are often taught to caregivers in NHs:

1. Engage the person in one-on-one conversation in a quiet space that has minimal distractions.
2. Speak slowly and clearly.
3. Maintain eye contact.
4. Give the person plenty of time to respond so he or she can think about what to say.
5. Be patient and offer reassurance.

6. Ask one question at a time.
7. Ask yes or no questions.
8. Avoid criticizing or correcting. Instead, listen and try to find the meaning in what the person says. Repeat what was said to clarify.
9. Avoid arguing. If the person says something you don't agree with, let it be.
10. Offer clear, step-by-step instructions for tasks. Lengthy requests may be overwhelming.
11. Give visual cues. Demonstrate a task to encourage participation.
12. Written notes can be helpful when spoken words seem confusing.

These basic communication techniques should not be used too prescriptively with all patients across the neuropsychiatric spectrum. Despite similarities, there are key differences between NH residents with dementia and NHPPRs. For NH caregivers, this paper therefore reviews how to adapt basic communication techniques for specific use with many NHPPRs. Because adapting or adding strategies will lead to an increased reservoir of communication skills in general, acquiring these nuances in communication will improve NH caregivers' communication with NH residents with dementia.

Background

I work in a large state psychiatric facility, where I have served as a psychiatric mental health nurse practitioner for several years. I work on the only unit that focuses on chronically ill psychiatric clients with SMI. At their extremes, depression, anxiety, and personality disorders can manifest as SMI. However, in general, these problems are not accompanied by psychosis, nor do they have the extreme morbidity of bipolar disorders, major depression with psychotic features, schizophrenia, or schizoaffective disorder—the five disorders generally referred to as

SMI (Agency for Healthcare Research and Quality, 2016). Because of the chronicity of these disorders, such psychiatric clients are likely to find themselves institutionalized in psychiatric state hospitals and NHs. It is important to note that Bipolar II disorder maybe an exception to the SMI classification for bipolar disorder. In this form of bipolar disorder, the depressive phase does not include psychosis; the highs are milder and may even make people more productive. Thus in this article, *bipolar disorder* refers to Bipolar 1, which is the disorder's more debilitating form. Psychiatric clients with milder forms of psychiatric illness are often able to live independently or be cared for in nonhospital settings, such as psychiatric group homes.

The particular unit where I work is a specialty unit and may be best be thought of as a step-down unit. By and large, the state hospital's goal is to quickly stabilize patients, and then as soon as possible to discharge them to an outpatient community health center, where their care can continue in a less restrictive environment. In this way, the most beds can be freed up to allow more acute psychiatric patients to be admitted. The criterion for admission is that the client must be of harm to self or others, and the criterion for discharge is that they must no longer consistently meet the criterion for admission.

The specialty unit exists for patients with SMI who cannot be quickly stabilized or who no longer are acutely of harm to self or others, but who are still at high risk for rapid deterioration if discharged to an outpatient setting. Catering to a more chronic population, the specialty unit has the time to try a few more in-depth treatments or medication trials than could be tried on acute units. The chronic nature of the specialty unit's unique population can be seen in a specific subgroup of our population: psychiatric clients who have been readmitted multiple times to the state hospital for their SMI. These patients are often admitted directly to the specialty unit, because of their anticipated longer stays.

Even on the specialty unit, there is always pressure to discharge our clients to a less restrictive setting, because of the high demand for psychiatric inpatient beds. The ethical tenets emphasizing patient autonomy in psychiatric hospitals since the legislation for de-institutionalization exert pressure to discharge patients as soon as possible as well. Often this means discharging them while they are still quite psychiatrically ill. Discharge options for our patients are always limited, so in one sense the patients who can qualify for NH placement are fortunate, because many specialty patients do not have the comorbid medical conditions that might require NH admission. Because so many specialty unit patients do end up in NHs, I have a special interest in advocating for NHs to provide a recovery-oriented atmosphere for psychiatric clients with SMI.

Discharge options for specialty patients include discharge to family, a structured psychiatric group home, or an NH. NHs are a frequent option, not only because they are a less restrictive environment, but also because many patients with chronic SMI also have co-occurring medical conditions that qualify them for NH placement.

Almost all patients on the specialty unit wish to be discharged to home. However, after many years of family members' having to cope with the patient's chronic mental illness, many family members are no longer willing to take the patient in, especially in the case of the psychiatric patient who is medically ill enough to qualify for NH placement. Patients also tend to prefer psychiatric group home settings to NHs, because they are more likely to have patients who are contemporaries in terms of age and mental and physical health. Research shows that the average age of NHPPRs is 65, whereas almost half of the clients in an NH are 85 or older, with very few who are 65 and younger (Aschbrenner et al., 2011). Often, psychiatric patients who can qualify for NH placement would prefer to stay at the state hospital rather than go to an NH. In

such cases, if patients lack the capacity to make important decisions for themselves, the mental health staff will appeal to the patient's guardian in order to override the patient's decision not to go to an NH. In the large number of psychiatric patients without guardians, incapacity must be established, and guardianship must be applied for; due to high demand, this is a lengthy process.

Not only is it a problem that state hospital patients often do not want to be in an NH; it is often the case that NHs do not want to admit psychiatric clients. Many NH applications for specialty patients who qualify for NH placement are rejected. Just as when guardianship approval must be obtained, these NH rejections result in NH-bound patients forced to wait until an NH willing to accept a psychiatric placement can be found. The reasons for this are understandable. Many NHs face pressure from their regulatory bodies not to use first- or second-generation antipsychotics due to the FDA's black box warnings for the use of these medications in elderly patients with dementia, who have a higher risk for cardiac events and death when taking them. NH administrators also face pressure to minimize the use of restraints.

NH administrators can view psychiatric patients to be at high risk for use of both restraints and antipsychotics. In most psychiatric hospitals, it is known that therapeutic communication is one way to keep the use of both chemical and physical restraints at a minimum, which is an excellent reason for NH staff to learn communication strategies that do not provoke NHPPRs. However, the use of antipsychotics is a mainstay of treatment for the five SMI diagnoses, and it cannot be eliminated in this population. Attempts to do so by naïve NH administrators can lead to the greater use of restraints.

Long stays due to difficulty in obtaining an NH placement can result in an inverse problem: caregivers in psychiatric facilities may end up with a medically acute population of

individuals whom many feel ill-equipped to deal with. NHs and psychiatric facilities need to work closely together to provide an optimal continuity of care for NH-bound psychiatric clients.

Co-occurring medical conditions

As stated earlier, often the decision for NH placement is based on a patient's having a co-occurring medical condition. In many instances, this will be a somatic illness such as diabetes or problems with mobility, rather than a neurological condition. These residents tend to be younger, more physically able, and mentally higher functioning than most NH residents.

Sometimes, the co-occurring medical condition may be neurological, like those common in the general NH population, such as Parkinson's, Huntington's, Alzheimer's, or vascular dementia and post stroke syndromes. These neurological comorbidities tend to be severe and may obscure the NHPPR's psychiatric diagnosis. In such cases, the NHPPR will look very similar to the NH resident with dementia and will benefit from the proven basic communication skills in which NH caregivers have most likely been trained.

Often because NRPPRs have been dealing with the chronicity of their psychiatric illness for years or even decades, these patients may also have neurological deficits secondary to their psychiatric conditions, which can further make distinctions between NH residents with dementia and NHPPRs murky. Consider patients with permanent short-term memory loss due to having multiple electroconvulsive therapy treatments over the course of decades, or patients who have developed encephalopathy as the side effect of chronic use of certain mood stabilizers, or those with poorly controlled schizophrenia, where it is known that repeated psychotic episodes over time shrink the frontal lobe: in these cases, the neurological deficits will not tend to be as severe as the primary non-psychiatric-related neurological conditions listed above.

Because of the harm that can be done by not attending to key differences between NH residents with dementia and NHPPRs, one must be able to differentiate neuropsychiatric symptoms between these two groups. Here I focus more on communication strategies for higher functioning NHPPRs—those who have a co-occurring somatic medical condition only, or if they do have a neurological condition, one that is less severe, or secondary to their psychiatric illness. Compared with lower functioning NHPPRs, these residents are the most different from NH residents with dementia, and they may experience the most harm if care and communication are not specifically tailored to their needs.

Differences in expression of psychosis between NHPPRs and NH residents with dementia

Delusions and hallucinations are psychiatric symptoms that are commonly expressed in both the NH resident with dementia and the NHPPR (MoreThanCognition.com, 2020) . Therefore, to tailor communication strategies for each group, it is important to understand how each group uniquely experiences these symptoms.

Increasing evidence from neuroimaging suggests cerebral lateralization for delusions in the elderly (MoreThanCognition.com, 2020). Late-onset delusions tend to originate in the right hemisphere (Holt & Albert, 2006). These are mainly delusions of misidentification. Examples of misidentification delusions are that deceased individuals are still living, that one's home is not one's home, and that a family member is someone else or an imposter (Holt & Albert, 2006).

In contrast, the positive symptoms of schizophrenia are characterized by less reality-based, bizarre, complex delusions and hallucinations that tend to originate in the left hemisphere (Holt & Albert, 2006). This is true even though negative symptoms of schizophrenia (social withdrawal, apathy, and other emotional deficits) become increasingly prominent as patients with schizophrenia age. Furthermore, systematic observation studies in geriatric psychiatry

wards reveal that delusions in the elderly do not share other characteristic symptoms of schizophrenia such as thought withdrawal, thought insertion, and thought broadcasting (Alicic-Evcimen et al., 2003). These symptoms are part of the cluster of symptoms referred to as Schneiderian first-rank symptoms. They are typical of early-onset schizophrenia and are not typically seen in patients with Alzheimer's (Häfner et al., 2001).

Although delusions of persecution are common to both dementia and the psychosis primarily associated with the psychiatrically ill, these persecutory delusions are more complex in psychiatric patients with SMI. For example, delusions of persecution in Alzheimer's dementia tend to be about infidelity or abandonment, whereas a typical persecutory delusion in schizophrenia would be about being spied on by someone who is part of an elaborate conspiracy. Part of this complexity in primary psychiatric patients is related to greater variance in the perceptual disturbances experienced, with auditory delusions the most prevalent. In comparison, perceptual disturbances in dementias of older age are expressed almost exclusively as visual hallucinations (Murray et al., 2014).

Basic communications techniques

The basic techniques listed by the Alzheimer's Association (2020) are typical of communication strategies taught in most NH caregiver orientations. These techniques work well with NH residents with dementia because they keep conversations very simple, limit distraction, and are reassuring for the client with cognitive losses. The NHPPR often does not have actual cognitive losses. However, in some SMI diagnoses—major depression, bipolar depression, and schizophrenia with predominantly negative symptoms—patients will experience “impoverishment of thoughts,” which can mimic dementia. In these cases, NHPPRs can clearly benefit from the basic communication strategies taught in NHs. However, there are notable

exceptions, depending on the particular communication strategy and whether or not the NHPPR is experiencing psychiatric symptoms at the moment.

Severity of psychiatric illness can be another indicator for a caregiver to consider when determining how to tailor communication strategies to certain patients. The issue of severity of illness demonstrates how, even within the NHPPR population, basic communication strategies will sometimes suffice—as, for example, when one is communicating with NHPPRs who as the result of their SMI or its treatment have developed severe neurological damage. Like NH residents with dementia, these NHPPRs will be also be highly distractible and will find MANY conversations to be cognitively challenging or emotionally draining. When neurological damage is not severe in the NHPPR, adapting the basic strategies will be met with more success.

Communication strategies tailored for NHPPRs

NHPPRs, particularly those in remission from their psychiatric symptoms, are likely to experience the basic techniques for communication as overly simplistic, and they may even reinforce the patient's sense of sickness. Communicating in such a prescriptive way with higher functioning NHPPRs would be analogous to someone always speaking loudly and slowly to older adults regardless of whether or not they have hearing deficits.

Many NHPPRs are used to the culture of psychiatric facilities, where they have lived much of their lives. Patients may have experienced various parts of that culture as either healing or offensive. As a result, some of the techniques on the Alzheimer's Association's list have been criticized. For example, the first technique on the list assumes a preference for individual quiet conversations, but because group therapy or milieu therapy is extremely prevalent in psychiatric hospitals, many NHPPRs may prefer group interactions—a livelier milieu than can be had at an NH.

Conversely, too much repeating back what was said, also known as “parroting,” might be experienced as irritating by veteran psychiatric inpatients, who have been known to refer to this technique as “psychobabble.” It is good to remember that many patients have likely endured many well-meaning students in nursing, psychology, and social work practicing beginning communication techniques on them.

Another criticism of these techniques (e.g., yes/no questions; repeat back without criticism; avoiding argument) is that, especially when overused, they will likely lack the complexity and challenge that NHPPRs could benefit from. More lively spontaneous conversations offer more opportunities for the NHPPR to be cognitively stimulated. For example, asking open-ended questions will yield more informative, useful answers and allow for more self-expression than will the yes/no questions that NH residents with dementia may benefit from. The table in the appendix shows in more detail how basic communication strategies can be adapted to work best with NHPPRs, corresponding to the Alzheimer’s list. Items 9, 10, 11, and 12 are omitted from the table, owing to their problematic simplicity, and their implications are already addressed in the preceding items.

This article is intended to increase awareness about the special needs of the growing population of NHPPRs. Given the considerable overlap between NH residents with dementia and NHPPRs, generalization of care and communication strategies from the NH resident with dementia to the NHPPR is common. But it will not lead to the best outcomes for NHPPRs, who tend to be younger and more cognitively intact. The key differences in NHPPRs that allow for communications strategies to be omitted or adapted in NHPPRs are important. NH caregivers should be aware of these differences so that they can help newly admitted NHPPRs achieve the highest quality of life possible in the NH setting.

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Appendix Communication Techniques for NHPPRs

Basic Technique	Rationale for adapting basic technique	Adapted or new strategy for NHPPRs
<p>1. Engage the person in one-on-one conversation in a quiet space that has minimal distractions.</p>	<p>Some extremely depressed patients may experience one-on-one conversations as too interpersonally intense. Psychiatric patients have said things like, “I feel like I’m being analyzed or under a microscope,” and thus they may prefer the anonymity that a group can offer.</p>	<p>A support group can be a way for a person to experience companionship, as well as many of Yalom’s (2005) curative factors without feeling the pressure to participate.</p>
<p>2. Speak slowly and clearly, and ask 1 question at a time.</p>	<p>Manic patients will often disregard or talk over caregivers who are speaking too slowly.</p>	<p>Manic patients can benefit from the caregiver’s matching or mirroring their accelerated speech and gestures. This will allow the caregiver to begin leading the interaction by slowing the pace. The manic patient will often follow the caregiver’s lead, because the mirroring and matching establishes a measure of trust.</p>
<p>3. Maintain eye contact.</p>	<p>Many psychiatric patients often have anxiety, low self-esteem, and social anxiety and therefore can easily feel self-conscious or intimidated by eye contact. Similarly, certain negative symptoms of schizophrenia (e.g., reduced social drive, loss of motivation, lack of social interest, and inattention to social or cognitive input) are also characterized by lack of eye contact.</p> <p>Making eye contact, especially if prolonged, can cause paranoid schizophrenics, who struggle with delusions of thought insertion or thought withdrawal, to think the person making eye contact is inserting or withdrawing thoughts into or from them.</p>	<p>Individuals with these conditions may prefer talking while walking side by side, in such a way that offers breaks from eye contact.</p>

<p>4. Give the person plenty of time to respond so he or she can think about what to say.</p>	<p>Psychotic patients who have auditory hallucinations will have more time to be distracted by internal stimuli if you allow too much time between your comments.</p>	<p>Keep the conversation going at a pace that does not allow the patient to drift internally.</p>
<p>5. Be patient and offer reassurance. It may encourage the person to explain his or her thoughts.</p>	<p>Providing reassurance to a grandiose or manic patient might encourage more flight of ideas and racing thoughts. "Hello Mr. Jones, I can see you have a lot on your mind, I cannot talk, at length, right now, but I do have 5 minutes to spare. After 5 minutes, the caregiver can avert her gaze or look at her watch to give nonverbal cues for the patient to discourage further communication.</p>	<p>Remaining neutral, setting firm limits, or subtle nonverbal redirecting cues can be a better way of helping contain the excessive energy often seen in grandiosity and mania, and can help the patient feel more in control.</p>
<p>6. Ask one question at a time. 7. Ask yes or no questions. For example, "Would you like some coffee?" rather than "What would you like to drink?"</p>	<p>Depressed patients will have difficulty making decisions, but do need to practice decision making beyond simple yes/no options.</p>	<p>Offering limited choices is a balanced way to help patients practice decision making without overwhelming their frontal lobe with open-ended questions.</p>
<p>8. Avoid criticizing or correcting. Instead, listen and try to find the meaning in what the person says. Repeat what was said to clarify.</p>	<p>While grandiose or manic clients may not have the insight to process constructive criticism at the moment, they may be able to process it eventually.</p>	<p>Constructive criticism and thoughtful feedback, especially within the context of a therapeutic relationship, will provide an important check on the narcissism of patients with grandiose mania.</p>