N323 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 2/15/22	**Patient Initials** S.P	**Age** 25	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Disabled (Does not work)	**Marital Status** Single	**Allergies** No known allergies
Code Status Full code	**Observation Status** Inpatient, Q15 minute rounds	**Height** 5'7"	**Weight** 130 lb

Medical History (5 Points)

Past Medical History:

Bacterial vaginosis

Significant Psychiatric History:

Significant suicidal history, Self-harm via cutting and self-induced head trauma, Bipolar II disorder, ADHD, PTSD, anxiety, "blackout" periods where patient claims to be violent, depression, auditory hallucinations.

Family History:

The patient was unable to provide much insight into her family's medical history as she was put into the foster care system at a young age. She did know that her biological mother had bipolar I as well as schizophrenia.

Social History (tobacco/alcohol/drugs):

The patient claimed she had no prior history of tobacco, or alcohol use, but she did admit to using cocaine 2 years ago.

Living Situation:

The patient is currently living in an apartment with a 19-year-old female. The patient claims that their relationship is very strained and they haven't been getting along.

Strengths:

Patient is willing to seek help she needs it.

Support System:

The patient claims that her foster family and cousins are very involved with her care. During my time at the facility the patient called her foster mother and talked at length about her treatment and her hospital stay.

Admission Assessment

Chief Complaint (2 points):

Suicidal ideations and anxiety

Contributing Factors (10 points):

My patient's depression and anxiety has been worsening over the past few months following the death of her grandfather due to covid pneumonia. Shortly before the patient self-admitted herself to the facility she had got into an altercation with her roommate. The roommate accused her of being on drugs (her toxicology came back negative for all illicit drugs) and said she needed to go get help. After the argument the patient left their apartment very upset and called the police and told them she had plans to commit suicide. The police came to her aide and she was then transported to OSF for care.

Factors that lead to admission:

Significant history of mental illness including but not limited to, self-harm, bipolar disorder, PTSD, anxiety, and depression. As stated previously, the patient expressed that the last year had been very difficult for her and the altercation with the roommate exacerbated her illness.

History of suicide attempts:

The patient stated “I have tried to kill myself at least 100 times, probably more. I usually try to overdose or jump off bridges and stuff”. The patient did not give me specific dates or times of these instances although it was noted in the chart that she was hospitalized in 2021 for an overdose.

Primary Diagnosis on Admission (2 points):

Suicidal ideations

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: **Witness of trauma/abuse:** n/a				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**
Physical Abuse	Denies	Denies	n/a	n/a
Sexual Abuse	Denies	Denies	n/a	n/a
Emotional Abuse	Not currently	Throughout her childhood	n/a	The patient stated “When I was in foster care, the parents were good to me but the kids always bullied me.

				It was horrible. It was very traumatizing".
Neglect	Denies	Denies	n/a	n/a
Exploitation	Denies	Denies	n/a	n/a
Crime	Denies	Denies	n/a	n/a
Military	Never enlisted	Never enlisted	n/a	n/a
Natural Disaster	Denies	Denies	n/a	n/a
Loss	Denies	Denies	n/a	n/a
Other	Denies	Denies	n/a	n/a

Presenting Problems			
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Depressed or sad mood	**Yes**	**No**	Denies
Loss of energy or interest in activities/school	**Yes**	**No**	Denies
Deterioration in hygiene and/or grooming	**Yes**	**No**	Upon physical examination it did appear that the patient had poor dental care but this could be due to being the foster care system for most of her life and not having excess to a dentist. Otherwise, the patient appeared to be well groomed and was dressed in street clothes.
Social withdrawal or isolation	**Yes**	**No**	Denies
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	Denies
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers	**Yes**	**No**	Patient claimed, "I only sleep

of hours/night			about 5 hours a night, every night".
Difficulty falling asleep	**Yes**	**No**	Denies
Frequently awakening during night	**Yes**	**No**	Patient stated "I wake up every few hours each night".
Early morning awakenings	**Yes**	**No**	Denies
Nightmares/dreams	**Yes**	**No**	Denies
Other	**Yes**	**No**	Denies
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	The patient stated "It's not that I don't' want to eat. I just don't have an appetite really". The patient claimed that she thinks it's due to her medication and that she doesn't feel like this all the time. The patient did appear to be well nourished. No physical signs of malnourishment were noted.
Binge eating and/or purging	**Yes**	**No**	Denies
Unexplained weight loss? **Amount of weight change:**	**Yes**	**No**	Denies
Use of laxatives or excessive exercise	**Yes**	**No**	Denies
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	While talking with the patient I did notice she was very hyperactive. She has a fidget toy that she was messing with and would jump around from topic to topic.
Panic attacks	**Yes**	**No**	The patient claims to have panic attacks every day that last 15 minute. She rates them a 9/10.
Obsessive/ compulsive thoughts	**Yes**	**No**	Denies
Obsessive/	**Yes**	**No**	Denies

compulsive behaviors				
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	Denies	
Rating Scale				
How would you rate your depression on a scale of 1-10?	0/10, patient does not have complaints of depression at this time			
How would you rate your anxiety on a scale of 1-10?	9/10			
Current Stressors of Areas of Life Affected by Presenting Problem (work, school, family, legal, social, financial)				
Problematic Area	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Work	**Yes**	**No**	n/a	
School	**Yes**	**No**	n/a	
Family	**Yes**	**No**	n/a	
Legal	**Yes**	**No**	n/a	
Social	**Yes**	**No**	Before admission patient had an alteration with her roommate, but seems to be getting along with staff, students, and other patients at this present time.	
Financial	**Yes**	**No**	Patient is trying to go back to school and claims she is “stressed out” over her finances.	
Other	**Yes**	**No**	**n/a**	
Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/**	**Inpatient/**	**Reason for**	**Response/**

	MD/ Therapist	Outpatient	Treatment	Outcome
1/8	**Inpatient** **Outpatient** **Other:** ER visit Dr. Feiteng Su, M.D.	ER visit/ Impatient visit	Patient had experienced one of her "blackouts" and was found in the front yard of her apartment complex. She suspected she was sexually assaulted and left there.	**No improvement** Patient did not want a rape kit or HIV/AIDS prophylactics but agreed to take STI prophylactics. At this time patient is still experiencing these "blackout" periods. **Some improvement** **Significant improvement**
1/19	**Inpatient** **Outpatient** **Other:** Dr. Feiteng Su, M.D.	Impatient	Patient experiencing "blackout" periods before she gets violent.	**No improvement** Patient had a similar "blackout" period within the same month. **Some improvement** **Significant improvement**
n/a	**Inpatient** **Outpatient** **Other:**	n/a	n/a	**No improvement** **Some improvement** **Significant improvement**
Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Female roommate	19	Friend/ roommate	**Yes**	**No**

n/a			**Yes**	**No**
n/a			**Yes**	**No**
n/a			**Yes**	**No**
n/a			**Yes**	**No**

If yes to any substance use, explain: n/a

Children (age and gender): Patient has no children

Who are children with now? n/a

Household dysfunction, including separation/divorce/death/incarceration: n/a

Current relationship problems: Patient did say she had a boyfriend and claims "he was sleeping around on me, so I left him". She said this wasn't the first time he has cheated on her.
Number of marriages: Never married

Sexual Orientation:	**Is client sexually active?**	**Does client practice safe sex?**
Bisexual	**Yes** **No**	**Yes** **No**

Please describe your religious values, beliefs, spirituality and/or preference:

Patient did not have any religious values or preferences.

Ethnic/cultural factors/traditions/current activity:

Patient did not have any cultural traditions.

Describe: n/a

Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): Patient said her roommate has called the cops on her before, but no charges were ever filed.

How can your family/support system participate in your treatment and care?

Engage in daily phone calls while in the inpatient setting, and accompany her to follow up

appointments.

Client raised by:

Natural parents
Grandparents

Adoptive parents **Foster parents** Patient had been in the foster system her whole life and has had 2-3 foster families, but now has an adopted family. **Other (describe):**
Significant childhood issues impacting current illness: The patient claims she experienced a lot of emotional abuse from the other children with her in the foster care system.
Atmosphere of childhood home: **Loving** **Comfortable** **Chaotic** **Abusive** **Supportive** **Other:**
Self-Care: **Independent** **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) Patient said her biological mother had bipolar I and schizophrenia
History of Substance Use: Patient claims to have done cocaine 2 years ago, but denies drug use, although she was hospitalized last year for an overdose.
Education History: **Grade school** **High school** **College** **Other:** Patient is in the process of applying to college
Reading Skills: **Yes** **No** **Limited**
Primary Language: English

Problems in school: The patient said she had no problems throughout school and even said “she loved it”.
Discharge
Client goals for treatment: Remain compliant with medications, therapy, and be able to identify triggers that cause her emotional distress.
Where will client go when discharged? The client is set to discharge back home

Outpatient Resources (15 points)

Resource	Rationale
1. Elliott counseling group-12 week anger management group- **Located in Champaign/ Urbana**	**1.** Patient experiences periods she calls “blackouts” where she can become violent. This program aims to understand anger, how it develops, patterns/triggers, and anger management tips. This program uses REBT and CBY to help patients gain control over their anger.
2. The rock counseling group-**Located in Champaign**	**2.** There are a wide variety of counselors at The rock counseling group that specialize in the areas by patient struggles with. Such as anger, suicidal ideations and self harm.
3. National Suicide Prevention Hotline- **800-273-8255**	**3.** I would like my patient to have quick access to the number for the National Suicide Prevention Hotline since she has a history of suicidal ideation and suicidal attempts. This hotline provides 24/7, free, support for those who are in distress.

Current Medications (10 points)

Complete all of your client's psychiatric medications

Brand/Generic	Aripiprazole/ Abilify	Benztropine/ Cogentin	Benztropine mesylate/ Cogentin	Haloperidol/ Haldol	Haloperidol/Haldol
Dose	5 mg	2 mg	2 mg	5 mg	5 mg
Frequency	Once Daily	BID	BID	Q6, PRN	Q6
Route	P.O	P.O	IM	IM *given if unable to take orally	P.O
Classification	Atypical antipsychotic	Anticholinergic	Anticholinergic	Antipsychotic	Antipsychotic
Mechanism of Action	May produce antipsychoic effects through partial agonist and antagonist actions. This medications as a partial agonist at dopamine receptors and serotonin receptors (Jones and Bartlett, 2020).	Blocks acetylcholine's actions and this restores the brain's dopamine levels which decreases rigidity and tremors (Jones and Bartlett, 2020)	Blocks acetylcholine's actions and this restores the brain's dopamine levels which decreases rigidity and tremors (Jones and Bartlett, 2020)	Blocks postsynaptic dopamine receptors and dopamine turnover in the brain, causing an antipsychotic effect (Jones and Bartlett, 2020)	Blocks postsynaptic dopamine receptors and dopamine turnover in the brain, causing an antipsychotic effect (Jones and Bartlett, 2020)
Therapeutic Uses	To treat agitation associated with bipolar mania	To decrease tremors	To decrease tremors	To treat acute psychotic episodes	To treat acute psychotic episodes
Therapeutic Range (if applicable)	n/a	n/a	n/a	2-15 ng/ml	2-15 ng/ml
Reason Client Taking	To treat bipolar mania and agitation	Movement disorder	Movement disorder	Psychosis/mania	Psychosis/mania
Contraindications (2)	Hypersensitivity to apriprazole or its components	Angle-closure glaucoma, presence of tardive dyskinesia	Angle-closure glaucoma, presence of tardive dyskinesia	Hypersensitivity to haloperidol or its components, Parkinson's disease	Hypersensitivity to haloperidol or its components, Parkinson's disease
Side Effects/Adverse Reactions (2)	Homicidal ideation, suicidal ideation	Agitation, hypotension	Agitation, hypotension	Hypothermia, seizures	Hypothermia, seizures
Medication/ Food Interactions	Antihypertensives: enhances effects Benzodiazepines: increased risk of orthostatic hypotension and sedition Carbamazepine: increased	Haloperidol: increased schizophrenic symptoms, decreased serum haloperidol level, and development of tardive dyskinesia	Haloperidol: increased schizophrenic symptoms, decreased serum haloperidol level, and development of tardive dyskinesia	anticholinergic medications, cabergoline, ketoconazole, lithium, methyldopa, drugs for Parkinson's disease, paroxetine, pergolide, quinupristin/dalfopristin, rifampin, saquinavir.	anticholinergic medications, cabergoline, ketoconazole, lithium, methyldopa, drugs for Parkinson's disease, paroxetine, pergolide, quinupristin/dalfopristin, rifampin, saquinavir.

	clearance and decrease blood level of Abilify				
Nursing Considerations (2)	Monitor CBC as ordered due to serious hematologic reactions may occur, monitor for neuroleptic malignant syndrome	Expect to administer I.V or I.M when patient needs more rapid response, give drug before or after meals depending on patients response	Expect to administer I.V or I.M when patient needs more rapid response, give drug before or after meals depending on patients response	Watch for tardive dyskinesia in patients on term long therapy, Assess patient for fall risks such as those with orthostatic hypotension	Watch for tardive dyskinesia in patients on term long therapy, Assess patient for fall risks such as those with orthostatic hypotension

Brand/Generic	Hydroxyzine/ Atarax	Lithium carbonate	Zolpidem tartrate/Ambien	Loratadine/ Claritin	Acetaminophen/ Tylenol
Dose	25 mg	300 mg	10 mg	10 mg	650 mg
Frequency	TID	BID	Once every HS	Once daily	Q4
Route	P.O	P.O	P.O	P.O	P.O
Classification	Piperazine derivate	Alkali metal	Imidazopyridine	Antihistamine	Nonsalicylate, Para aminophenol derivative
Mechanism of Action	Competes with histamine for histamine receptor sites on surfaces or effector cells. This suppresses results of histamine activity, including edema, flare, and pruritis. Sedative actions occur at subcortical level of CNS and are dose related (Jones and Bartlett, 2020).	May increase presynaptic degradation of the catecholamine neurotransmitters dopamine, norepinephrine, and serotonin; inhibit their release at neuronal synapses; and decrease postsynaptic receptor sensitivity (Jones and Bartlett, 2020).	May potentiate the effect of gamma-aminobutyric acid and other inhibitory neurotransmitters. By binding to specific receptors in the limbic and cortical areas of the CNS, zolpidem increase GABAs inhibitory effects (Jones and Bartlett, 2020).	Loratadine is highly selective for histamine H1-receptors. This competitive antagonism blocks the effects of histamine on H1-receptors in the GI tract, uterus, large blood vessels, and bronchial muscle (Jones and Bartlett, 2020).	Inhibits the enzyme cyclooxygenase. Blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system (Jones and Bartlett, 2020).
Therapeutic Uses	To relieve anxiety	To treat acute mania episodes or bipolar	To treat insomnia	Seasonal or perennial allergies	To relieve mild to moderate pain

		disorder			
Therapeutic Range (if applicable)	n/a	0.8-1.2 mEq/L	0.08-0.15 mg/	n/a	5-20 mcg/ml
Reason Client Taking	For anxiety	For mania related to bipolar disorder	Patient wakes in the middle of the night, and Ambien can be used when a middle of the night awakening occurs and the patient can not get back to sleep and has more than 4 hours of sleep remaining before wake time.	To treat allergies	To relive occasion mild pains
Contraindications (2)	Breastfeeding, hypersensitivity to hydroxyzine or its components	Concurrent use if diuretics, hypersensitivity to lithium or its components	Hypersensitive to zolpidem or it components, sever hepatic impairment	Hepatic impairment, renal impairment	Hypersensitive to acetaminophen or its components, severe hepatic impairment
Side Effects/Adverse Reactions (2)	Dizziness, Nausea	Ataxia, Bradycardia	Suicidal ideation, respiratory depression	Seizures, bronchospasm	Hepatoxicity, Hypokalemia
Medication/Food Interactions	Aripiprazole, lithium, haloperidol, zolpidem, benztropine	Hydroxyzine, caffeine containing food and drink, foods high in sodium, zolpidem, haloperidol, aripiprazole,	Aripiprazole, benztropine, haloperidol, hydroxyzine	Acetaminophen, hydroxyzine	Anticholinergics, oral contraceptives, alcohol use
Nursing Considerations (2)	Don't give subq or IV route because this can cause tissue necrosis, Observe for over sedation	Maintain therapeutic levels, take this drug exactly as prescribed either with food or after meals	Monitor patient closely for suicidal tendencies, Expect patient to receive no more than a months supply for out patient therapy	This drug may cause drowsiness; don't operate machinery, can not be used while breastfeeding	Monitor renal function in long term therapy, monitor liver function in long term therapy

Medications Reference (1) (APA):

Jones & Bartlett. (2020). *2020 Nurse's Drug Handbook (19th ed.).* Jones & Bartlett Learning.

Mental Status Exam Findings (20 points)

APPEARANCE:	Patient appear well groomed but had poor dental hygiene. Patient appears slightly younger than her stated age. Wearing pants with rainbow mustaches on them.
Behavior:	Hyperactive
Build:	Slender build
Attitude:	Cheerful, happy to have company
Speech:	Speech clear, but childlike
Interpersonal style:	Expressive, talkative, engaged, oriented
Mood:	Calm
Affect:	Affect is euphoric
MAIN THOUGHT CONTENT:	
Ideations:	Suicidal
Delusions:	**n/a**
Illusions:	**n/a**
Obsessions:	**n/a**
Compulsions:	**n/a**
Phobias:	**n/a**
ORIENTATION:	A&O x4
Sensorium:	N/A
Thought Content:	Scattered, logical but lacking direct
MEMORY:	Intact, both short- and long-term memory appear normal
Remote:	
REASONING:	
Judgment:	Poor judgment
Calculations:	N/A
Intelligence:	Average
Abstraction:	N/A
Impulse Control:	Poor
INSIGHT:	Fair

GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	 None Poor posture, slouching during our conversations Normal muscle tone Average strength Good motor movements

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1406	112 bpm	116/76 mm Hg	17 breaths per minute	98.8 F	99% Room air
1715	108 bpm	114/75 mm Hg	18 breaths per minute	98.3 F	98% Room air

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1406	Numerical	n/a	0/10	n/a	n/a
1715	Numerical	n/a	0/10	n/a	n/a

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast:** n/a **Lunch:** n/a **Dinner:** n/a	**Oral Fluid Intake with Meals (in mL)** **Breakfast:** n/a **Lunch:** n/a **Dinner:** Filled a 400 ml cup of water for the patient before I left the unit.

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

The patient plans to discharge home with her roommate, but ideally, I'd like her to find a less hostile environment to live once her financial situation improves. I would like her to seek anger management treatment as well as establish long term care with a psychiatrist. The patient is to stay compliant with her medications and go to follow up appointments as directed.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Immediate Interventions (At admission)**	**Intermediate Interventions (During hospitalization)**	**Community Interventions (Prior to discharge)**
1. Risk for other-directed violence related to mental illness as evidence by history of violent behaviors	The patient has a history of blackout periods and becomes violent. The patient has had the cops called on her before for threats of violence towards others.	1.Provided a low stimulation environment to avoid increasing agitation 2. Remove all objects from the environment that the patient could use to injure others 3. Instruct staff members to maintain and convey a calm attitude towards the patient	1. Administer prescribed medications to help the patient control aggressive behavior and remain calm 2. Set limits on the patients behavior to reinforce the expectation that the patient will act in a responsible, controlled manner 3. Express understanding of the patients feelings and encourage open discussing	1. Patient will attend and successfully complete an anger management course. 2. Patient will establish a daily routine of strenuous exercise and encourage the patient to adhere to it. Exercise provides an alternative way to deal with stress and frustrations 3. Journal to express negative emotions
1. Risk for self directed violence related to depression	The patient has a history of self-mutilation via cutting.	1. Asking the patient "Have you thought about killing yourself" and "Do you have a	1. Supervise the administration of medications	1. Make appropriate referrals to mental health professionals to help the patient

as evidence by previous suicide attempts		plan". 2. Initiate safety protocols by removing hazardous objects from the room 3. Make a short term contract with the patient that she won't hurt herself during a specific period of time.	2.15 minute rounding to ensure patient safety 3. Use warm, caring, nonjudgmental manner to show unconditional positive regard	work through suicidal feelings and develop healthier alternatives. 2. Help the patient set a goal for obtaining long-term psychiatric care 3. Provide the crisis hotline phone number
2. Social isolation related to inadequate personal resources as evidence by feelings of being different from others	I choose this diagnosis because my patient expressed that she felt like she never fit in growing up and still feels that way.	1. Inform family of patient status 2. Allow patient to contact family members 3. Admission to inpatient psych floor	1. Encourage the patient to engage in group meetings 2. Encourage the patient to sit with others during meal time 3. Encourage the patient to engage in group activities on the unit, such as Uno	1. Establish a living situation that no longer feels hostile in which family can visit 2. Encourage the patient to get involved in community programs 3. Encourage the patient to start community college as she has already expressed interest in doing so.

Other References (APA):

Concept Map (20 Points):

Subjective Data

"I have tried to kill myself at least 100 times, probably more. I usually try to overdose or jump off bridges and stuff".
The patient stated "When I was in foster care, the parents were good to me but the kids always bullied me. It was horrible. It was very traumatizing".
"I only sleep about 5 hours a night, every night".
"It's not that I don't' want to eat. I just don't have an appetite really".
"he was sleeping around on me, so I left him".

Nursing Diagnosis/Outcomes

Risk for other-directed violence related to mental illness as evidence by history of violent behaviors
Patient will use alternative methods to decompress without being violent

Risk for self directed violence related to depression as evidence by previous suicide attempts
Patient will be able to identify triggers and journal to express feelings in a safe way

Social isolation related to inadequate personal resources as evidence by feelings of being different from others
Patient will get involved in community groups and socialize with those she share things in common with

Objective Data

Patients most recent vitals:
HR: 112
B/P: 116/76
RR: 17
Temp: 98.8
Oxygen sat: 99% room air

Patient Information

On February 15th, a 25-year-old white, female was admitted to OSF Heart of Mary for suicidal ideations following a fight with her 19-year-old female roommate. The patient has a significant history of self-harm, anxiety and depression a lot with several other mental health diagnosis.

Nursing Interventions

1. Administer prescribed medications to help the patient control aggressive behavior and remain calm

2. Set limits on the patient's behavior to reinforce the expectation that the patient will act in a responsible, controlled manner

3. Express understanding of the patient's feelings and encourage open discussing

1. Encourage the patient to engage in group meetings

2. Encourage the patient to sit with others during mealtime

3. Encourage the patient to engage in group activities on the unit, such as Uno

1. Supervise the administration of medications

2.15 minute rounding to ensure patient safety

3. Use warm, caring, nonjudgmental manner to show unconditional positive regard