



A Guide to

# MENTAL HEALTH AND PSYCHIATRIC NURSING

S E C O N D E D I T I O N

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*Foreword*  
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# A Guide to MENTAL HEALTH AND PSYCHIATRIC NURSING

**SECOND EDITION**

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# 1

## Mental Health and Mental Illness

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### MENTAL HEALTH

It is a state of balance between the individual and the surrounding world, a state of harmony between oneself and others, a co-existence between the realities of the self and that of other people and the environment.

### Definitions

Karl Menninger (1947) defines mental health as “An adjustment of human beings to the world

and to each other with a maximum of effectiveness and happiness.”

The American Psychiatric Association (APA 1980) defines mental health as: “Simultaneous success at working, loving and creating with the capacity for mature and flexible resolution of conflicts between instincts, conscience, important other people and reality”.

Thus mental health would include not only the absence of diagnostic labels such as schizophrenia and obsessive compulsive disorder, but also the ability to cope with the stressors of daily living, freedom from anxieties and generally a positive outlook towards life's vicissitudes and to cope with those.

### Components of Mental Health

The components of mental health include:

- **The ability to accept self :** A mentally healthy individual feels comfortable about himself. He feels reasonably secure and adequately accepts his shortcomings. In other words, he has self-respect.
- **The capacity to feel right towards others :** An individual who enjoys good mental health is able to be sincerely interested in other's welfare. He has friendships that are satisfying and lasting. He is able to feel a part of a group without being submerged by it. He takes responsibility for his neighbors and his fellow members.
- **The ability to fulfill life's tasks :** The third important component of mental health is that

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it bestows on an individual the ability to meet the demands of life. A mentally healthy person is able to think for himself, set reasonable goals and take his own decision. He does something about the problems as they arise. He shoulders his daily responsibilities, and is not bowled over by his own emotions of fear, anger, love or guilt.

### Criteria for Mental Health

- Adequate contact with reality
- Control of thoughts and imagination
- Efficiency in work and play
- Social acceptance
- Positive self-concept
- A healthy emotional life

### Indicators of Mental Health

Jahoda (1958) has identified six indicators of mental health which include:

#### 1. A positive attitude towards self

This includes an objective view of self, including knowledge and acceptance of strengths and limitations. The individual feels a strong sense of personal identity and security within the environment.

#### 2. Growth, development and the ability for self actualization

This indicator correlates with whether the individual successfully achieves the tasks associated with each level of development.

#### 3. Integration

Integration includes the ability to adaptively respond to the environment and the development of a philosophy of life, both of which help the individual maintain anxiety at a manageable level in response to stressful situations.

#### 4. Autonomy

Refers to the individual's ability to perform, in an independent self-directed manner; the individual makes choices and accepts responsibility for the outcomes.

#### 5. Perception of reality

This includes perception of the environment without distortion, as well as the capacity for empathy and social sensitivity- a respect and concern for the wants and needs of others.

#### 6. Environmental mastery

This indicator suggests that the individual has achieved a satisfactory role within the group, society or environment. He is able to love and accept the love of others.

### Characteristics of a Mentally Healthy Person

- He has an ability to make adjustments.
- He has a sense of personal worth, feels worthwhile and important.
- He solves his problems largely by his own effort and makes his own decisions.
- He has a sense of personal security and feels secure in a group, shows understanding of other people's problems and motives.
- He has a sense of responsibility.
- He can give and accept love.
- He lives in a world of reality rather than fantasy.
- He shows emotional maturity in his behavior, and develops a capacity to tolerate frustration and disappointments in his daily life.
- He has developed a philosophy of life that gives meaning and purpose to his daily activities.
- He has a variety of interests and generally lives a well-balanced life of work, rest and recreation.

### MENTAL ILLNESS

Mental illness is maladjustment in living. It produces a disharmony in the person's ability to meet human needs comfortably or effectively and function within a culture.

A mentally ill person loses his ability to respond according to the expectations he has for himself and the demands that society has for him.

In general an individual may be considered to be mentally ill if:

- the person's behavior is causing distress and suffering to self and/or others
- the person's behavior is causing disturbance in his day-to-day activities, job and interpersonal relationships.

## Definition

Mental and behavioral disorders are understood as clinically significant conditions characterized by alterations in thinking, mood (emotions) or behavior associated with personal distress and/or impaired functioning. (WHO, 2001)

## Characteristics of Mental Illness

- Changes in one's thinking, memory, perception, feeling and judgment resulting in changes in talk and behavior which appear to be deviant from previous personality or from the norms of community
- These changes in behavior cause distress and suffering to the individual or others or both
- Changes and the consequent distress cause disturbance in day-to-day activities, work and relationship with important others (social and vocational dysfunction).

## Features of Mental Illness

The features of mental illness are classified under four headings

- Disturbances in bodily functions
- Disturbances in mental functions
- Changes in individual and social activities
- Somatic complaints

### 1. Disturbances in Bodily Functions

- Sleep:* Disturbed sleep throughout the night, or no sleep at all, or difficulty in falling asleep, or waking up in the middle of night and failing to fall asleep again. In addition, the individual may experience lethargy and lack of freshness in the morning.
- Appetite and food intake:* Increased appetite or decreased appetite, weight loss or weight gain, nausea, vomiting.

- Bowel and bladder movement:* Diarrhea or constipation, increased micturition, bed-wetting.
- Sexual desire and activity:* Decreased interest in sex, premature ejaculation, impotence or lack of sexual satisfaction. In some conditions there can be excessive sexual desire or lack of social inhibitions.

### 2. Disturbances in Mental Functions

- Behavior:* The patient may exhibit over activity, restlessness, irritability, may be abusive to others for trivial or no reasons at all, or the patient may become dull, withdrawn and not respond to external or internal cues. At times the patient may behave in a bizarre way which the family members may find irritating. Sometimes the patient's behavior can be dangerous to self or others.
- Speech:* Patient talks excessively and unnecessarily or talks very little or stays mute. The talk becomes irrelevant and un-understandable (incoherent).
- Thought:* Patient expresses peculiar and wrong beliefs which others do not share.
- Emotions:* Patient may exhibit excessive emotions like excessive happiness, anger, fear or sadness. Sometimes emotions can be inappropriate to situations. He may laugh to self or weep without any reason.
- Perception:* The patient may perceive without any stimulus. There can be misinterpretation of perception. For example a mentally ill person can see things or hear sounds or feel objects which do not exist or which others do not see. This is known as hallucinations. A patient who is hallucinating is seen talking to self, laughing or weeping to self, wandering in the streets and behaving in a manner which others may find abnormal.
- Attention and concentration:* Patient may have decreased attention and concentration; he may get distracted easily, or have selective inattention.
- Memory:* Patient may lose his memory and start forgetting important matters.

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- *Intelligence and judgment:* In some mental illnesses, intelligence and the ability to take decisions deteriorate. Patient loses reasoning skills and abilities, may not be able to perform simple arithmetic, or commits mistakes in routine work.
- *Level of consciousness:* In some mental illnesses due to possible brain damage there may be changes in the level of consciousness. Patient fails to identify his relatives. He can be disoriented to time and place. He may remain confused or become unconscious.

### 3. Changes in Individual and Social Activities

Patients may neglect their bodily needs and personal hygiene. The patient may also lose social sense. They behave in an inappropriate manner in social situations and embarrass others. They behave strangely with their family members, friends, colleagues and others. They may insult, abuse/assault them.

### 4. Somatic Complaints

Patient may complain of aches and pains in different parts of the body, fatigue, weakness, involuntary movements, etc.

### Common Signs and Symptoms of Mental Illness

#### *Disturbances in Motor Behavior*

Motor retardation, stupor, stereotypes, negativism, ambivalence, waxy flexibility, echopraxia, restlessness, agitation and excitement.

*Disorders of thought, language and communication*  
Pressure of speech, poverty of speech, dysarthria, flight of ideas, circumstantiality, loosening of association, tangentiality, incoherence, perseveration, neologism, clang association, thought block, thought insertion, thought broadcasting, echolalia, delusions, obsessions and phobias.

#### *Disorders of perception*

Illusions, hallucinations, depersonalization, derealization.

#### *Disorders of emotion*

Blunt affect, labile affect, elated mood, euphoria, ecstasy, dysphoric mood, depression, anhedonia.

#### *Disturbances of consciousness*

Clouding of consciousness, delirium and coma.

#### *Disturbances in attention*

Distractibility, selective inattention.

#### *Disturbances in orientation*

Disorientation of time, place or person.

#### *Disturbances of memory*

Amnesia, confabulation.

#### *Impaired judgment*

#### *Disturbances in biological function*

Persistent deviations in temperature, pulse and respiration, nausea, vomiting, headache, loss of appetite, increased appetite, loss of weight, pain, fatigue, weight gain, insomnia, hypersomnia and sexual dysfunction.

### CONCEPTS OF NORMAL AND ABNORMAL BEHAVIOR

Psychiatry as evident from the above is concerned with abnormal behavior in its broadest sense, but defining the concepts of normal and abnormal behavior as such has been found to be difficult. These concepts are much under the influence of sociocultural factors.

Several models have been put forward in order to explain the concept of normal and abnormal behavior. Some of them are:

#### **Medical Model**

Medical model considers organic pathology as the definite cause for mental disorder. According to this model abnormal people are the ones who have disturbances in thought, perception and psychomotor activities. The normal are the ones who are free from these disturbances.

#### **Statistical Model**

It involves the analysis of responses on a test or a questionnaire or observations of some particular

behavioral variables. The degree of deviation from the standard norms arrived at statistically, characterizes the degree of abnormality.

Statistically normal mental health falls within two standard deviations (SDs) of the normal distribution curve.

### **Sociocultural Model**

The beliefs, norms, taboos and values of a society have to be accepted and adopted by individuals. Breaking any of these would be considered as abnormal. Normalcy is defined in context with social norms prescribed by the culture. Thus cultural background has to be taken into account when distinguishing between normal and abnormal behavior.

### **Behavior Model**

Behavior that is adaptive, is normal, maladaptive is abnormal. Abnormal behavior is a set of faulty behaviors acquired through learning.

## **PROBLEMS OF MENTAL DISORDERS**

- Self-care limitations or impaired functioning related to mental illness
- Significant deficits in biological, emotional and cognitive functioning
- Disability, life-process changes
- Emotional problems such as anxiety, anger, sadness, loneliness and grief
- Physical symptoms that occur along with altered psychological functioning
- Alteration in thinking, perceiving, communicating and decision making
- Difficulties in relating to others
- Patient's behavior may be dangerous to self or others
- Adverse effects on the well-being of the individual, family and community
- Financial, marital, family, academic and occupational problems.

## **BURDEN OF MENTAL DISORDERS**

Mental disorders are common, affecting more than 25 percent of all people at some time during

their lives. They are also universal, affecting people in all countries and societies, individuals of all ages, women and men, the rich and the poor, from urban and rural environments. They have an economic impact on societies and on the quality of life of individuals and families.

- Mental disorders at any point of time are present in about 10 percent of the adult population. Around 20 percent of all patients seen by primary health care professionals have one or more mental disorders.
- During the last two decades many epidemiological studies have been conducted in India, which show that mental disorders prevail in 18 to 207 per 1000, with median 65.4 per 1000 at any given time. About 2.3% of the population suffers from seriously incapacitating mental disorders or epilepsy. A large number of adult patients (10.4% to 53.0%) coming to the general out patient department are diagnosed as mentally ill.
- It is estimated that in 2000, mental disorders accounted for 12% of the total Disability Adjusted Life Years (DALYs) lost due to all diseases and injuries. Common disorders, which usually cause severe disability, include depressive disorder, substance use disorders, schizophrenia, epilepsy, Alzheimer's disease, mental retardation and disorders of childhood and adolescence.
- More than 450 million people today suffer from mental and behavioral disorders. Within the next 20 years depression will have the dubious distinction of becoming the second biggest cause for global burden of disease.
- Worldwide 70 million people suffer from alcohol dependence, 50 million from epilepsy, 24 million from schizophrenia and another 20 million people attempt suicide every year.
- Global Burden of Disease (GBD) 2000 estimates show that mental and neurological conditions account for 30.8% of all Years Lived with Disability (YLD). Depression causes the largest amount of disability, accounting for almost 12% of all disabilities. Six neuropsychiatric conditions figured in the top

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- twenty causes of disability worldwide which include:
- Unipolar depressive disorders
  - Alcohol use disorders
  - Schizophrenia
  - Bipolar affective disorders
  - Alzheimer's and other dementias
  - Migraine
- Mental illnesses cause massive disruption in the lives of individuals, families and communities. Individuals suffer the distressing symptoms of disorders. They also suffer because they are unable to participate in work and leisure activities often as a result of discrimination. They worry about not being able to shoulder their responsibilities towards their family and friends and are fearful of being a burden to others. Mental illnesses are common to all countries and cause immense suffering. People with these disorders are often subjected to social isolation, poor quality of life and increased mortality. These disorders are thus the cause of staggering economic and social costs.
  - It is estimated that one in four families has at least one member currently suffering from a mental illness. These families are required not only to provide physical and emotional support, but also to bear the negative impact of stigma and discrimination present in all parts of the world.
  - Families in which one member is suffering from a mental disorder make a number of adjustments and compromises that prevent other members of the family from achieving their full potential in work, social relationships and leisure. These are the human aspects of the burden of mental disorders that are difficult to assess and quantify.
  - The impact of mental disorders in communities is large and manifold. There is the cost of providing care, the loss of productivity and certain legal problems associated with some mental disorders.

### MENTAL HEALTH FACTS

- One in four patients visiting a health service has at least one mental, neurological or behavioral disorder but most of these disorders are neither diagnosed nor treated.
- Barriers to effective treatment of mental illness include lack of recognition of the seriousness of mental illness and lack of understanding about the benefits of services. Policy makers, insurance companies, health and labor policies and the public at large—all discriminate between physical and mental health problems.
- Most middle and low-income countries devote less than 1% of their health expenditure to mental health. Consequently, mental health policies, legislation, community care facilities, and treatment for people with mental illness are not given the priority they deserve.
- More than 40% of countries have no mental health policy and over 30% have no mental health program. Over 90% of countries have no mental health policy that includes children and adolescents. In addition health plans frequently do not cover mental and behavioral disorders at the same level as other illnesses, creating significant economic difficulties for patients and their families. Therefore, the suffering continues and difficulties grow.
- There is a wide gap between availability and implementation of effective interventions, e.g. in India, treatment rates for schizophrenia and epilepsy are reported to be 20% of all cases in need of treatment, compared to 80% for the same disorders in the west.
- There is an urgent need to sensitize governments on the importance of mental health and clearly define the goals and objectives of community-based health programs. Mental health services should be integrated into the overall primary health care system. Innovative community-based health programs which are culturally and gender appropriate and reach out to all segments of the population need to

be developed. Well-organized community-based care is urgently required besides increasing the number of psychiatric beds in the general hospitals; governments must take the responsibility for ensuring that mental health policies are developed and implemented. Strategies like including the integration of mental health treatment and services into the general health system, particularly into primary health care, must be pursued.

### **MENTAL HEALTH ISSUES**

There are a number of new issues that have come up in the country with implications for mental health. The most notable are alcohol policies, violence in society, the growing population of elderly persons, urbanization, mental health of women, disaster care, migrants and refugees, street children, and stress at the work place. These new problems pose serious challenges to existing mental health services and infrastructure.

The National Rural Health Mission (NRHM) has overlooked various ground realities related to mental health. There is a shortage of manpower, and training programs are not able to meet the demands in providing training to all medical private practitioners and medical officers. Appropriate mental health can be provided at the sub centre and village level by minimum training of the health workers that will help in providing comprehensive health care at the most peripheral level. It is necessary to integrate National Mental Health Program and District Mental Health Program and include mental health in National Rural Health Mission to achieve health for all.

### **MINIMUM ACTIONS REQUIRED**

- Formulating policies designed to improve the mental health of populations
- Assuring universal access to appropriate and cost-effective services (including mental health promotion and prevention services)
- Ensuring adequate care and protection of human rights for institutionalized patients with most severe mental disorders

- Assessing and monitoring mental health in communities
- Promoting healthy lifestyles and reducing risk factors for mental disorders
- Supporting stable family life, social cohesion and human development
- Continuing research in related areas
- Introducing mental health care activities in workplace and schools
- Use of mass media to promote mental health, foster positive attitude, and help prevent disorders.

(Source: Syed Amin Tabish, JK-practitioner 2005, 12 (1) : 34 – 38).

### **MAGNITUDE OF THE PROBLEM IN INDIA**

The common psychiatric illnesses encountered in a clinic of a General Hospital are—Neurotic disorders (e.g. anxiety neurosis, obsessive-compulsive disorder and reactive depression), psychosomatic disorders (e.g. hypertension, diabetes mellitus, peptic ulcer, tension headaches, etc.), functional psychosis (e.g. schizophrenia, mania and depression) and organic psychosis.

In a child guidance clinic, the common mental illnesses include mental retardation, conduct disorder, hyperkinetic syndrome, enuresis, etc. In a geriatric clinic the common disorders are depression, dementia, delusional disorders, etc. In a psychosexual clinic the common problems include Dhat syndrome, premature ejaculation, erectile impotence and so on.

The prevalence of psychiatric disorders is 58.2 per thousand which means that there are about 5.7 crore people suffering from some sort of psychiatric disturbance. Out of this 4 lakh people have organic psychoses, 26 lakh people have schizophrenia and 1.2 crore people have affective psychosis; thus there are about 1.5 crore people suffering from severe mental disorders, besides 12,000 patients in government mental hospitals in the country (Reddy et al, 1996).

### **ETIOLOGY OF MENTAL ILLNESS**

Many factors are responsible for the causation of mental illness. These factors may predispose an

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individual to mental illness, precipitate or perpetuate the mental illness.

### **Predisposing Factors**

These factors determine an individual's susceptibility to mental illness. They interact with precipitating factors resulting in mental illness.

These are:

- Genetic make up
- Physical damage to the central nervous system
- Adverse psychosocial influence

### **Precipitating Factors**

These are events that occur shortly before the onset of a disorder and appear to have induced it.

These are:

- Physical stress
- Psychosocial stress

### **Perpetuating Factors**

These factors are responsible for aggravating or prolonging the diseases already existing in an individual. Psychosocial stress is an example.

Thus etiological factors of mental illness can be:

- Biological factors
- Physiological changes
- Psychological factors
- Social factors

### **Biological Factors**

#### *Heredit*y

What one inherits is not the illness or its symptoms, but a predisposition to the illness, which is determined by genes that we inherit directly. Studies have shown that three-fourths of mental defectives and one-third of psychotic individuals owe their condition mainly to unfavorable heredity.

#### *Biochemical Factors*

Biochemical abnormalities in the brain are considered to be the cause of some psychological disorders. Disturbance in neurotransmitters in the

brain is found to play an important role in the etiology of certain psychiatric disorders.

### **Brain Damage**

Any damage to the structure and functioning of the brain can give rise to mental illness. Damage to the structure of the brain may be due to one of the following causes:

- Infection: E.g. Neurosyphilis, encephalitis, HIV infection, etc.
- Injury: Loss of brain tissue due to head injury
- Intoxication: Damage to brain tissue due to toxins such as alcohol, barbiturates, lead, etc.
- Vascular: Poor blood supply, bleeding (intracranial hemorrhage, subarachnoid hemorrhage, subdural hemorrhage)
- Alteration in brain function: Changes in blood chemistry that interfere with brain functioning such as disturbance in blood glucose levels, hypoxia, anoxia, and fluid and electrolyte imbalance
- Tumors: Brain tumors
- Vitamin deficiency and malnutrition, in particular deficiency of vitamin B complex
- Degenerative diseases: Dementia
- Endocrine disturbances: Hypothyroidism, thyrotoxicosis etc.
- Physical defects and physical illness: Acute physical illness as well as chronic illnesses with all their handicapping conditions may result in loss of mental capacities

### **Physiological Changes**

It has been observed that mental disorders are more likely to occur at certain critical periods of life namely – puberty, menstruation, pregnancy, delivery, puerperium and climacteric. These periods are marked not only by physiological (endocrine) changes, but also by psychological issues that diminish the adaptive capacity of the individual. Thus the individual becomes more susceptible to mental illness during this period.

### **Psychological Factors**

- It is observed that some specific personality types are more prone to develop certain

psychological disorders. For example those who are unsocial and reserved (schizoid) are vulnerable to schizophrenia when they face adverse situations and psychosocial stresses.

- Psychological factors like strained interpersonal relationships at home, place of work, school or college, bereavement, loss of prestige, loss of job, etc.
- Childhood insecurities due to parents with pathological personalities, faulty attitude of parents (over-strictness, over leniency), abnormal parent-child relationship (over-protection, rejection, unhealthy comparisons), deprivation of child's essential psychological and social needs, etc.
- Social and recreational deprivations resulting in boredom, isolation and alienation.
- Marriage problems like forced bachelorhood, disharmony due to physical, emotional, social, educational or financial incompatibility, childlessness, too many children, etc.
- Sexual difficulties arising out of improper sex education, unhealthy attitudes towards sexual functions, guilt feelings about masturbation, pre and extra-marital sex relations, worries about sexual perversions.
- Stress, frustration and seasonal variations are sometimes noted in the occurrence of mental diseases.

### Social Factors

- Poverty, unemployment, injustice, insecurity, migration, urbanization
- Gambling, alcoholism, prostitution, broken homes, divorce, very big family, religion, traditions, political upheavals and other social crises

### MISCONCEPTIONS ABOUT MENTAL ILLNESS

Beliefs about mental illness have been characterized by superstition, ignorance and fear. Although time and advances in scientific understanding of mental illness have dispelled many false ideas, there remain a number of popular misconceptions. Some of them are:

- *Mental illness is caused by supernatural power and is the result of a curse or possession by evil spirit:* Many people do not consider mental illness as an illness, but possession by spirits or curse that has befallen on the patient or family because of past sins or misdeeds in previous life.
- *Mentally ill people show bizarre behavior:* Patients in mental hospitals and clinics are often picturised as a weird lot, who spend their time exhibiting useless bizarre behavior like twisting of hands, etc.
- *Mentally ill people are dangerous:* People who have or had a mental illness are viewed with suspicion and as dangerous persons.
- *Mental illness is something to be ashamed of:* This idea arouses an unsympathetic, cruel attitude towards a mentally ill person. This is the reason why many people hide mental illness in the family.
- *Mental illness is not curable:* People object to have normal relationship with mentally ill people, or to give them employment even after being cured, or even to accept them as neighbors.
- *Mental illness is contagious:* The fear that it is contagious is the main false notion which leads people to view suspiciously, or object to marital relations with a person belonging to the household of the mentally ill.
- *Mental illness is hereditary:* It is not a rule that children of mentally ill patients should become mentally ill.
- *Marriage can cure mental illness:* A mentally ill person can get worse if he gets married when he is ill, as marriage can become an additional stress. A patient who has recovered can get married and live a normal life like any other person.
- *Mental hospitals are places where only dangerous mentally ill individuals are treated and restraint is a major form of treatment:* People hesitate to take their relatives to mental hospitals for treatment because of fear. Further, as ex-patient of a mental hospital, he, as well as his family members are often isolated. Therefore, people seek help from mental hospitals only as a last resort.

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### General Attitude toward the Mentally Ill

- In general the community responds to the mentally ill through denial, isolation and rejection. There is also a lack of understanding of mental illness as any other illness, and a lack of tendency to reject both the patients and those who treat them.
- Mentally ill are viewed as people with no capacity for understanding.
- People feel mental illness cannot be cured, and even if the patient gets better, complete physical rest is considered essential.
- The mentally ill are by and large perceived as aggressive, violent and dangerous.

An individual's values and personal beliefs affect his attitude about mental illness, the mentally ill and treatment of mental illness. There still exists a stigma surrounding individuals who need or use psychiatric mental health services. The need continues for public education to modify or alter misconceptions about mental illness and people with mental disorders.

### MENTAL HEALTH TEAM OR MULTIDISCIPLINARY TEAM

Multidisciplinary approach refers to collaboration between members of different disciplines who provide specific services to the patient.

The multidisciplinary team includes:

- A Psychiatrist
- A Psychiatric nurse
- A Clinical psychologist
- A Psychiatric social worker
- An Occupational therapist or an Activity therapist
- A Pharmacist and a dietitian
- A Counselor

A **Psychiatrist** is a medical doctor with special training in psychiatry. He is accountable for the medical diagnosis and treatment of patient. Other important functions are:

- Admitting patient into acute care setting
- Prescribing and monitoring psychopharmacologic agents
- Administering electroconvulsive therapy

- Conducting individual and family therapy
- Participating in interdisciplinary team meetings
- Owing to their legal power to prescribe and to write orders, psychiatrists often function as leaders of the team.

A **Psychiatric nurse** is a registered nurse with specialized training in the care and treatment of psychiatric patients; she may have a Diploma, MSc., M.Phil. or Ph.D in psychiatric nursing. She is accountable for the bio-psychosocial nursing care of patients and their milieu. Other functions include:

- Administering and monitoring medications
- Assisting in numerous psychiatric and physical treatments
- Participate in interdisciplinary team meetings
- Teach patients and families
- Take responsibility for patient's records
- Act as patient's advocate
- Interact with patients' significant others

A **Clinical psychologist** should have a Masters Degree in Psychology or Ph.D in clinical psychology with specialized training in mental health settings. He is accountable for psychological assessments, testing, and treatments. He offers direct services such as individual, family or marital therapies.

A **Psychiatric social worker** should have a Masters Degree in Social Work or Ph.D degree with specialized training in mental health settings. He is accountable for family case work and community placement of patients. He conducts group therapy sessions. He emphasizes intervention with the patient in social environment in which he will live.

A **Occupational therapist or an Activity therapist** is accountable for recreational, occupational and activity programs. He assists the patients to gain skills that help them cope more effectively to gain or retain employment, to use leisure time.

A **Counselor** provides basic supportive counseling and assists in psycho educational and recreational activities.

## CLASSIFICATION OF MENTAL DISORDERS

Classification is a process by which complex phenomena are organized into categories, classes or ranks so as to bring together those things that most resemble each other and to separate those that differ.

Like any growing branch of medicine, psychiatry has seen rapid changes in classification to keep up with a conglomeration of growing research data dealing with epidemiology, symptomatology, prognostic factors, treatment methods and new theories for causation of psychiatric disorders.

At present there are two major classifications in psychiatry, namely, ICD10 (1992) and DSM IV (1994).

*I. ICD10 (International Statistical Classification of Disease and Related Health Problems) – 1992*  
This is WHO's classification for all diseases and related health problems. The chapter 'F' classifies psychiatric disorders as mental and behavioral disorders and codes them on an alphanumeric system from F00 to F99.

### The main categories in ICD10

|                |  |
|----------------|--|
| <b>F00–F09</b> | <b>Organic, including symptomatic, mental disorders</b>                            |
| F00            | Dementia in Alzheimer's disease  |
| F01            | Vascular dementia  |
| F04            | Organic amnestic syndrome  |
| F05            | Delirium   |
| F06            | Other mental disorders due to brain damage and dysfunction and to physical disease |
| F07            | Personality and behavioral disorders due to brain disease, damage and dysfunction  |
| <b>F10–F19</b> | <b>Mental and behavior disorders due to psychoactive substance use</b>             |
| F10            | Mental and behavioral disorders due to use of alcohol                              |
| F11            | Mental and behavioral disorders due to use of opioids                              |
| F12            | Mental and behavioral disorders due to use of cannabinoids                         |

|                |   |
|----------------|---|
| F13            | Mental and behavioral disorders due to use of sedatives or hypnotics                        |
| F14            | Mental and behavioral disorders due to use of cocaine                                       |
| F16            | Mental and behavioral disorders due to use of hallucinogens                                 |
| <b>F20–F29</b> | <b>Schizophrenia, schizotypal and delusional disorders</b>                                  |
| F20            | Schizophrenia   |
| F20.0          | paranoid schizophrenia  |
| F20.1          | hebephrenic schizophrenia   |
| F20.2          | catatonic schizophrenia   |
| F20.3          | undifferentiated schizophrenia  |
| F20.4          | post-schizophrenic depression   |
| F20.5          | residual schizophrenia  |
| F20.6          | simple schizophrenia  |
| F21            | Schizotypal disorder  |
| F22            | Persistent delusional disorders   |
| F23            | Acute and transient psychotic disorders   |
| F24            | Induced delusional disorders  |
| F25            | Schizoaffective disorders   |
| <b>F30–F39</b> | <b>Mood (affective) disorders</b>   |
| F30            | Manic episode   |
| F31            | Bipolar affective disorder  |
| F32            | Depressive episode  |
| F33            | Recurrent depressive disorder   |
| F34            | Persistent mood disorder  |
| <b>F40–F49</b> | <b>Neurotic, stress-related and somatoform disorders</b>                                    |
| F40            | Phobic anxiety disorders  |
| F41            | Other anxiety disorders   |
| F42            | Obsessive-compulsive disorder   |
| F43            | Reaction to severe stress, and adjustment disorders   |
| F44            | Dissociative (conversion) disorders   |
| F45            | Somatoform disorders  |
| <b>F50–F59</b> | <b>Behavioral syndromes associated with physiological disturbances and physical factors</b> |
| F50            | Eating disorders  |
| F51            | Non-organic sleep disorders   |
| F52            | Sexual dysfunction, not caused by organic disorder or disease                               |

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- F60–F69 Disorders of adult personality and behavior**
- F60 Specific personality disorders
  - F60.0 paranoid personality disorder
  - F60.1 schizoid personality disorder
  - F60.2 dissocial personality disorder
  - F60.3 emotionally unstable personality disorder
  - F60.4 histrionic personality disorder
  - F60.5 anankastic personality disorder
  - F60.6 anxious personality disorder
  - F60.7 dependent personality disorder
  - F61 Mixed and other personality disorders
  - F62 Enduring personality changes, not attributable to brain damage and disease
  - F63 Habit and impulse disorders
  - F64 Gender identity disorders
  - F65 Disorders of sexual preference
- F70–F79 Mental retardation**
- F70 Mild mental retardation
  - F71 Moderate mental retardation
  - F72 Severe mental retardation
  - F73 Profound mental retardation
- F80–F89 Disorders of psychological development**
- F80 Specific developmental disorders of speech and language
  - F81 Specific developmental disorders of scholastic skills
  - F82 Specific developmental disorder of motor function
  - F83 Mixed specific developmental disorders
  - F84 Pervasive developmental disorders
- F90–F98 Behavioral and emotional disorders with onset usually occurring in childhood and adolescence**
- F90 Hyperkinetic disorders
  - F91 Conduct disorders
  - F93 Emotional disorders with onset specific to childhood
  - F94 Disorders of social functioning with onset specific to childhood and adolescence
  - F95 Tic disorders

F98 Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence

**F99 Unspecified mental disorder**

*II. DSMIV (Diagnostic and Statistical Manual) -1994*  
This is the classification of mental disorders by the American Psychiatric Association (APA). The pattern adopted by DSM IV is of multiaxial systems.

A multiaxial system that evaluates patients along several versatiles contains five axes. Axis I and II make up the entire classification which contains more than 300 specific disorders.

*The five axes of DSM IV are*

**AXIS I:** Clinical psychiatric diagnosis

**AXIS II:** Personality disorder and mental retardation

**AXIS III:** General medical conditions

**AXIS IV:** Psychosocial and environmental problems

**AXIS V:** Global assessment of functioning in current and past one year

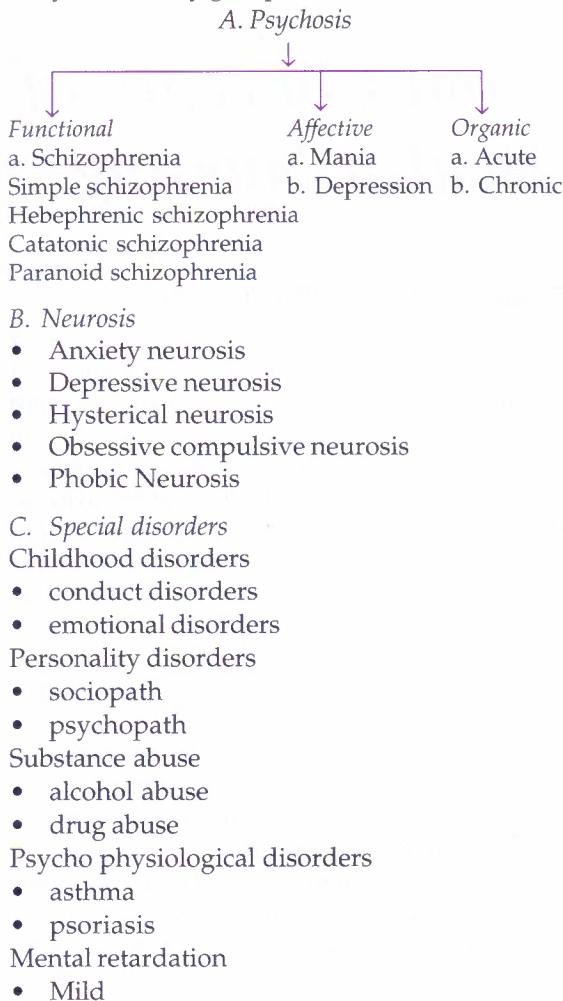
### Differences between ICD10 and DSM IV

|              | <i>ICD-10</i>  | <i>DSM-IV</i>  |
|--------------|--|--|
| Origin       | International  | American Psychiatric Association   |
| Presentation | Different versions for clinical work, research and primary care        | A single version   |
| Language     | Available in all widely spoken languages                               | English version only   |
| Structure    | Single axis  | Multiaxial   |
| Content      | Diagnostic criteria do not include social consequences of the disorder | Diagnostic criteria usually include occupational or other areas of functioning |

### III. Indian Classification

In India Neki (1963), Wig and Singer (1967), Vahia (1961) and Varma (1971) have attempted some

modifications of ICD8 to suit Indian conditions. They are broadly grouped as follows:



- Moderate
- Severe
- Profound

In everyday practice classification is made after the history and examination of mental state have been completed.

### REVIEW QUESTIONS

- Concepts of normal and abnormal behavior (Nov 2001, Oct 2006)
- Components of mental health (Nov 2003)
- Meaning of mental illness (Feb 2001, Oct 2004)
- Features of mental illness
- Mental health issues
- Characteristics of a mentally healthy person (Nov 1999, Apr 2003, Nov 2003)
- Misconceptions about mental illness (Nov 2003)
- Community attitude towards mentally ill (Nov 2002)
- Etiology of mental illness (Feb 2001, Apr 2002, Apr 2005, Oct 2006)
- Classification of mental disorders (Apr 2006)
- International classification of diseases (Oct 2004, Apr 2006)
- DSMIV (Nov 2003)
- Multidisciplinary team or mental health team
- Defence mechanisms— rationalization, projection, identification, reaction formation, undoing, negativism, repression (Oct 2000), regression, suppression (Oct 2000), fantasy or day dreaming.

# 2

# *Principles and Concepts of Mental Health Nursing*

- PSYCHIATRY
- PSYCHIATRIC NURSING
- DEVELOPMENT OF PSYCHIATRY
- DEVELOPMENT OF MODERN PSYCHIATRIC NURSING
- CURRENT ISSUES AND TRENDS IN CARE
- PSYCHIATRIC NURSING SKILLS
- STANDARDS OF MENTAL HEALTH NURSING
- GENERAL PRINCIPLES OF PSYCHIATRIC NURSING
- FUNCTIONS OF A PSYCHIATRIC NURSE
- QUALITIES OF A PSYCHIATRIC NURSE
- THERAPEUTIC ROLES OF A PSYCHIATRIC MENTAL HEALTH NURSE

Health is a state of complete physical, mental, social and spiritual well-being and not merely the absence of disease or infirmity. Both physical and mental healths are interdependent. A nurse who is responsible for total health care of a person must take care of both physical and emotional needs; therefore she should develop a basic understanding and skill in psychiatric nursing to achieve total health care.

## **PSYCHIATRY**

It is a branch of medicine that deals with the diagnosis, treatment and prevention of mental illness.

## **PSYCHIATRIC NURSING**

It is a specialized area of nursing practice, employing theories of human behavior as it is a science, and the purposeful use of self as it is an art, in the diagnosis and treatment of human responses to actual or potential mental health problems. (American Nurses Association, 1994) Thus psychiatric nursing deals with the promotion of mental health, prevention of mental illness, care and rehabilitation of mentally ill individuals both in hospital and community.

## **DEVELOPMENT OF PSYCHIATRY**

Historically, mental illness was viewed as a demonic possession, the influence of ancestral spirits, the result of violating a taboo or neglecting a cultural ritual and spiritual condemnation. As a result, the mentally ill were often starved, beaten, burnt, amputated and tortured in order to make the body an unsuitable place for the demon. Gradually, man began the quest for scientific knowledge and truth, which can be traced as follows:

- Pythagoras (580-510 BC) developed the concept that the brain is the seat of intellectual activity.
- Hippocrates (460 - 370 BC) described mental illness as hysteria, mania and depression.
- Plato (427 - 347 BC) identified the relationship between mind and body.
- Asciepiades, who is referred to as the Father of Psychiatry, made use of simple hygienic measures, diet, bath, massage in place of mechanical restraints.
- The Greeks were the first to study mental illness scientifically and separate the study of mind from religion. Aristotle, a Greek philosopher, emphasized on the release of repressed emotions for the effective treatment of mental illness. He suggested catharsis and music therapy for patients with melancholia.
- During the middle ages the mentally ill were not considered as outcasts, but as people to be helped. One of the great figures during this time was St. Augustine, who believed that although God acted directly in human affairs, people were responsible for their own actions.

- Renaissance in Europe (1300 – 1600 AD): This represented the saddest chapter in the history of psychiatry when it was believed that demons were the cause of hallucinations, delusions and sexual activity, and the treatment was torture and even death.

### Some Important Milestones

- 1773** The first mental hospital in the US was built in Williamsburg, Virginia.
- 1793** Phillip Pinel removed the chains from mentally ill patients confined in Bicetre, a hospital outside Paris, thus bringing about the first revolution in psychiatry.
- 1812** The first American textbook in psychiatry was written by Benjamin Rush, who is referred to as the Father of American Psychiatry.
- 1908** Clifford Beers, an ex-patient of a mental hospital, wrote the book, 'The Mind That Found Itself' based on his bitter experiences in the hospital. He founded the American Mental Health Association, which made a major contribution towards the improvement of conditions in mental hospitals.
- 1912** Eugene Bleuler, a Swiss psychiatrist coined the term 'schizophrenia'.  
—The Indian Lunacy Act was passed.
- 1927** Insulin shock treatment was introduced for schizophrenia.
- 1936** Frontal lobotomy was advocated for the management of psychiatric disorders.
- 1938** Electro Convulsive Therapy (ECT) was used for the treatment of psychoses.
- 1939** Development of psychoanalytical theory by Sigmund Freud led to new concepts in the treatment of mental illness.
- 1946** The Bhore Committee presented the situation with regard to mental health services. Based on its recommendations, 5 mental hospitals were set up at Amritsar (1947), Hyderabad (1953), Srinagar (1958), Jamnagar (1960) and Delhi (1966). An All India Institute of Mental Health was also set up at Bangalore (currently known as National Institute of Mental Health and Neurosciences or NIMHANS).
- 1949** Lithium was first used for the treatment of mania.
- 1952** Chlorpromazine was introduced which brought about a revolution in psychopharmacology and changed the whole picture of mental health care.
- 1963** The 'Community Mental Health Centers' Act was passed.
- 1978** The Alma-Ata declaration of "Health for All by 2000 A.D." posed a major challenge to Indian mental health professionals. In order to achieve mental health for all (as a part of the achievement of Health for All by 2000 A.D.), in 1980 the Government of India called for experts in the field for assessing the mental health needs of the people and recommended steps for providing mental health care.
- 1981** Community psychiatric centers were set up to experiment with primary mental health care approach at Raipur Rani, Chandigarh and Sakalwara, Bangalore.
- 1982** The Central Council of Health, India's highest health policy making body accepted the National Mental Health Policy and brought out the National Mental Health Program in India.
- 1987** The Indian Mental Health Act was passed.
- 1990** The Government of India formed an Action Group at Delhi to pool the opinions of mental health experts about the National Mental Health Program. National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore, has taken up the leadership in orienting health care professionals about the mental health programs of our country. A number of innovative approaches for the treatment and rehabilitation of mental illness have been initiated, and the most important ones are:
- Integration of mental health care with general health care.
  - School mental health programs.

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- Promotion of child mental health through the involvement of *angawadis* (ICDS program).
- Crisis intervention for suicide prevention.
- Halfway homes for mentally ill individuals for social skills training, vocational training.
- Education and involvement of the general public through the activities of non-governmental organizations.
- Media materials for public education.
- Training for non-professionals to work with mentally ill individuals.

### DEVELOPMENT OF MODERN PSYCHIATRIC NURSING

Psychiatric nursing in general arose from the need for hospitals to provide socially acceptable levels of care for patients.

#### Some Important Milestones

- 1872** First training school for nurses, based on the Nightingale system was established by the New England Hospital for Women and Children, USA. Linda Richards, the first nurse to graduate from the one-year course, developed 12 training schools in the USA.
- 1882** First school to prepare nurses to care for the mentally ill was opened at Mc Lean Hospital in Waverly. A two-year program was started but few psychological skills were addressed and much importance was given to custodial care such as personal hygiene, medication, nutrition, etc.
- 1913** Johns Hopkins became the first school of nursing to include a fully developed course for psychiatric nursing in the curriculum.

The important factor in the development of psychiatric nursing was the emergence of various somatic therapies like, insulin shock therapy (1927), psychosurgery (1936), and ECT (1938). These therapies required the medical surgical

skills of the nurses and increased the demand for improved psychological treatment for patients who did not respond well. As the nurses collaborated with the doctors in carrying out these therapies they struggled to define their role as psychiatric nurses.

Major growth of psychiatric nursing occurred after World War II because of the emergence of services related to psychiatric problems. The content of psychiatric nursing became an integral part of general nursing curriculum.

- 1943** Psychiatric nursing course was started for male nurses.
- 1946** Health Survey Committee's report recommended preparation of nursing personnel in psychiatric nursing also. The existing institutions like, mental hospitals in Bangalore and Ranchi should start the training.
- 1952** Dr. Hildegard Peplau defined the therapeutic roles that nurses might play in the mental health setting. She described the skills and roles of the psychiatric nurse in her book 'Interpersonal Relations in Nursing'. It was the first systematic theoretical framework developed for psychiatric nursing.
- 1953** Maxwell Jones introduced therapeutic community.
- 1956** One year post-certificate course in psychiatric nursing was started at NIMHANS, Bangalore.
- 1960** The focus began to shift to primary prevention and implementing care and consultation in the community. The name 'psychiatric nursing' was changed to 'psychiatric and mental health nursing,' and a second change was made in the 1970s when it was known as 'psychosocial nursing'.
- 1963** Journal of Psychiatric Nursing and Mental Health Services was published.
- 1964** Mudaliar committee felt the need for preparing a large number of psychiatric nurses and recommended inclusion of psychiatry in the nursing curriculum (as per International Council of Nursing).

- 1965** The Indian Nursing Council included psychiatric nursing as a compulsory course in the B.Sc Nursing program.
- 1973** Standards of Psychiatric and Mental Health Nursing practice were enunciated to provide a means of improving the quality of care.
- 1975** Psychiatric Nursing was offered as an elective subject in M.Sc Nursing at the Rajkumari Amrit Kaur College of Nursing, New Delhi. Now various colleges offer psychiatric nursing as an elective subject in M.Sc Nursing. These are SNDT College of Nursing, Mumbai; NIMHANS, Bangalore; College of Nursing, Ludhiana; College of Nursing, CMC, Vellore; Father Muller's College of Nursing, Mangalore; College of Nursing, Thiruvananthapuram; MAHE, Manipal; MV Shetty Institute of Health Sciences, Mangalore.
- 1980** Scientific advances in the area of psychobiology, brain imaging techniques, knowledge about neurotransmitters and neuronal receptors, molecular genetics related to psychiatry, etc, emerged. These contributed to the shift from psychodynamic models to more balanced psychobiological models of psychiatric care.
- 1986** The Indian Nursing Council (INC) made psychiatric nursing a component of General Nursing and Midwifery course.
- 1990** During these years integration of neurosciences into holistic biopsychosocial practice of psychiatric nursing occurred. Advances in understanding the interrelationships of brain, behavior, emotions and cognition offered many new opportunities for psychiatric nurses.
- 1994** The above mentioned changes led to the revision of Standards of Psychiatric and Mental Health Nursing.

The professional psychiatric nursing role has grown in complexity. In contemporary psychiatric nursing practice the role includes the parameters of clinical competence, patient advocacy, fiscal responsibility, professional

collaboration, social accountability, legal and ethical obligations.

### CURRENT ISSUES AND TRENDS IN CARE (SCOPE)

A psychiatric nurse faces various challenges because of changes in patient care approach. Some of these changes that affect her role are as follows:

#### *Demographic Changes*

- Type of family (increased number of nuclear families)
- Increasing number of the elderly group

#### *Social Changes*

- The need for maintaining intergroup and intragroup loyalties
- Peer pressure

#### *Economic Changes*

- Industrialization
- Urbanization
- Raised standard of living

#### *Technological Changes*

- Mass media
- Electronic systems
- Information Technology

#### *Mental Health Care Changes*

- Increased awareness in the public regarding mental health
- Need to maintain mental stability
- Increased mental health problems

The above changes set the current trends in mental health care. Some of these are:

#### *Educational Programs for the Psychiatric Nurse*

- Diploma in Psychiatric Nursing (The first program was offered in 1956 at NIMHANS, Bangalore).
- M.Sc in Psychiatric Nursing (The first program was offered in 1976 at Rajkumari Amrit Kaur College of Nursing, New Delhi).

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- M.Phil in Psychiatric Nursing (1990, M.G. University, Kottayam).
- Doctorate in Psychiatric Nursing (offered at MAHE, Manipal; RAK College of Nursing, Delhi; NIMHANS, Bangalore).
- Short-term training programs for both the degree and diploma holders in nursing.

### Standards of Mental Health Nursing

The development of standards for nursing practice is a beginning step towards the attainment of quality nursing care. The adoption of standards helps to clarify nurses' areas of accountability, since the standards provide the nurse, the health agency, other professionals, clients, and the public, with a basis for evaluating practice. Standards also define the nursing profession's accountability to the public. These standards are therefore a means for improving the quality of care for mentally ill people.

### Development of Code of Ethics

This is very important for a psychiatric nurse as she takes up independent roles in psychotherapy, behavior therapy, cognitive therapy, individual therapy, group therapy, maintains patient's confidentiality, protects his rights and acts as patient's advocate.

### Legal Aspects in Psychiatric Nursing

Knowledge of the legal boundaries governing psychiatric nursing practice is necessary to protect the public, the patient, and the nurse. The practice of psychiatric nursing is influenced by law, particularly in its concern for the rights of patients and the quality of care they receive.

The client's right to refuse a particular treatment, protection from confinement, intentional torts, informed consent, confidentiality, and record keeping are a few legal issues in which the nurse has to participate and gain quality knowledge.

### Promotion of Research in Mental Health Nursing

The nurse contributes to nursing and the mental

health field through innovations in theory and practice and participation in research.

### Cost Effective Nursing Care

Studies need to be conducted to find out the viability in terms of cost involved in training a nurse and the quality of output in terms of nursing care rendered by her.

### Focus of Care

A psychiatric nurse has to focus care on certain target groups like the elderly, children, women, youth, mentally retarded and chronic mentally ill.

### New Trends in Role of a Psychiatric Nurse

#### *Primary Mental Health Nursing*

Psychiatric nurses are moving into the domain of primary care and working with other nurses and physicians to diagnose and treat psychiatric illness in patients with somatic complaints. Cardiovascular, gynecological, respiratory, and gastrointestinal and family practice settings are appropriate for assessing patients for anxiety, depression and substance abuse disorders.

#### *Collaborative Psychiatric Nursing Practice*

Patients who are having difficulty being stabilized on their medications or who have co-morbid medical illnesses are seen in a psychiatric nursing clinic where nurses and physicians collaborate to provide high quality patient care.

#### *Registered Psychiatric Nurse (RPN)*

A Registered Psychiatric Nurse provides psychiatric mental health nursing care to individuals, families, and groups to enable them to function at an optimal level of psychological wellness through more effective adaptive behaviors and increased resilience to stress. She must be able to provide safe, basic physical care, have a wide understanding of psychological and developmental problems and their treatment and have a highly developed level of communication skills.

She works with children, adolescents, adults and elderly with dysfunctional behavior patterns, and developmental handicaps. A registered psychiatric nurse works as an independent entity. She works in various kinds of inpatient facilities and community settings.

### *Clinical Nurse Specialist (CNS)*

The Clinical Nurse Specialist provides consultative services to nursing personnel. She attends clinical teaching programs, demonstrates therapies, conducts in-service education programs, initiates and participates in curriculum revision/ changes and nursing research.

### *Case Management*

Using case management a psychiatric mental health nurse is responsible for assessing needs, identifying services, and monitoring and evaluating client status. A case manager coordinates care through collaboration with all involved health professionals ensuring accessibility and availability of care.

### *Nurse Psychotherapist*

The psychiatric nurse can take up psychotherapy roles as in individual therapy, group therapy, counseling, etc.

### *Psychiatric Nurse Educator*

The main function of psychiatric nurse educator is planning and changing the curriculum according to the needs of the society and learner. The Indian Nursing Council included psychiatric nursing as compulsory for the qualifying examination in B.Sc Nursing program in 1965, and from 1986 it became a component in General Nursing and Midwifery course as well.

The number of nurses in the field of teaching psychiatric nursing needs to be enhanced.

This is a big challenge for nursing curriculum planners.

### *Psychosocial Rehabilitation Nursing*

It is concerned with helping people with chronic

mental illness to lead more independent and satisfactory lives in the community.

### *Child Psychiatric Nursing*

In child psychiatric nursing the nurse identifies emotional and behavioral problems of the children and provides comprehensive care.

### *Gerontological and Geriatric Nursing*

Gerontological nursing provides emotional support to those people who have retired from services, who have no financial sources and helps them in understanding the situation, and developing new coping mechanisms.

Geriatric nursing is expanding the psychiatric nursing practice to aged people who have been affected by emotional and behavioral disorders such as dementia, chronic schizophrenia, delirium, etc.

### *Deaddiction Nursing*

A psychiatric nurse in these units identifies psychosocial problems and maintaining factors in addicts. She also provides various therapies to the addicts and their family members.

### *Neuropsychiatric Nursing*

Psychiatric nursing practice is extended to patients who are suffering from neuropsychiatric disorders such as dementia, epilepsy, brain tumor, head injury with behavioral problems, HIV infection with behavioral problems, etc.

### *Community Mental Health Nursing*

Community mental health nursing is the application of knowledge of psychiatric nursing in preventing mental illness, promoting and maintaining mental health of the people. It includes early diagnosis, appropriate referrals, care and rehabilitation of mentally ill people.

### *Advanced Practice Roles*

These include: Nursing leadership in forensic health units, crisis intervention, risk assessment and management in community settings.

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### PSYCHIATRIC NURSING SKILLS

Mental health nursing is the practice of promoting mental health as well as caring for people who have mental illness, potentiating their independency and restoring their dignity. In order to fulfill this arduous occupation, a mental health nurse must possess a sound knowledge base and the requisite skills for good nursing practice.

#### Prerequisites for a Mental Health Nurse

##### *Personal Skills*

*Self-awareness* It is a key component of psychiatric nursing experience. It is an answer to the question, "who am I". The nurse must be able to examine personal feelings, actions and reactions as a provider of care. A firm understanding and acceptance by the nurse allows acknowledging a patient's differences and uniqueness.

*Adaptability* A mental health nurse needs to be adaptable to different settings and cultures. Working within residential settings, for example, may demand attitudes and roles which are different from working in a community, as in a residential setting the nurse may have an authoritative or a supervisory role which she necessarily does not have in a community.

A mental health nurse also needs to cope with a variety of social and cultural settings. Social settings involve the class and status of the individuals while cultural settings involve race, ethnicity and gender. Therefore she may need to be familiar with the issues that arise in cross-cultural mental health nursing.

##### *Care values and attitudes*

These include:

- Self-awareness and self-esteem
- Respecting the person's rights
- Listening
- Responding with care and respect
- Supporting with trust and confidence
- Reassuring with explanation and honesty
- Physically nursing the helpless with compassion
- Carrying out procedures skillfully

- Working within personal and ethical boundaries.

##### *Counseling Skills*

These include:

- Unconditional positive regard/non-judgmental approach
- Empathy
- Warmth and genuineness
- Confidentiality
- Non-verbal sensitivity, non-verbal attending, non-verbal responding
- Other interpersonal skills required are paraphrasing, reflecting, clarifying, summarizing.

##### *Behavioral Skills*

These are based on Pavlovian principles and Skinner's principles. They include:

1. To increase adaptive behavior
  - Positive reinforcement
  - Negative reinforcement
  - Token economy
2. To decrease maladaptive behavior
  - Extinction
  - Time out
  - Restraining
  - Over correction
3. To teach new behavior
  - Modeling
  - Shaping
  - Chaining
  - Cueing.

##### *Supervisory Skills*

Supervision is an integral necessity for any worker in the caring profession, to ensure the best quality service for clients and best quality developmental opportunities for workers. A good supervisor requires interpersonal and professional skills, technical knowledge, leadership qualities and human skills.

##### *Crisis Skills*

Aggressive and assaultive behavior of violent patients, self-harm, acute alcohol intoxication are

some of the cases a nurse is likely to encounter in the course of her practice. Such situations may cause the nurse to feel overwhelmed with feelings of helplessness, powerlessness and inadequacy. Exercise of self-control, calm, rational thinking and identifying ways of obtaining help from the other people are some of the skills to be cultivated by the psychiatric nurse when confronted with such crises situations.

### **Teaching Skills**

This relates to the nurse's ability to explain, enabling full understanding on the part of the client. It also involves enhancing the client's environment in order to maximize his awareness of the things around him. It is necessary for the nurse to be enthusiastic about activities and choices of the clients and also give the client every opportunity to use his power of judgment in order to make decisions.

## **STANDARDS OF MENTAL HEALTH NURSING**

The purpose of Standards of Psychiatric and Mental Health Nursing practice is to fulfill the profession's obligation to provide a means of improving the quality of care. The standards presented here are a revision of the standards enunciated by the Division on Psychiatric and Mental Health Nursing Practice in 1973.

### **Professional Practice Standards**

#### ***Standard I: Theory***

The nurse applies appropriate theory that is scientifically sound as a basis for decisions regarding nursing practice. Psychiatric and mental health nursing is characterized by the application of relevant theories to explain phenomena of concern to nurses and to provide a basis for intervention.

#### ***Standard II: Data Collection***

The nurse continuously collects data that are comprehensive, accurate and systematic. Effective

interviewing, behavioral observation, physical and mental health assessment enable the nurse to reach sound conclusions and plan appropriate interventions with the client.

#### ***Standard III: Diagnosis***

The nurse utilizes nursing diagnoses and/or standard classification of mental disorders to express conclusions supported by recorded assessment data and current scientific premises.

Nursing's logical basis for providing care rests on the recognition and identification of those actual or potential health problems that are within the scope of nursing practice.

#### ***Standard IV: Planning***

The nurse develops a nursing care plan with specific goals and interventions delineating nursing actions unique to each client's needs.

The nursing care plan is used to guide therapeutic intervention and effectively achieve the desired outcomes.

#### ***Standard V: Intervention***

The nurse intervenes as guided by the nursing care plan to implement nursing actions that promote, maintain or restore physical and mental health, prevent illness and effect rehabilitation.

(a) ***Psychotherapeutic interventions*** The nurse uses psychotherapeutic interventions to assist clients in regaining or improving their previous coping abilities and to prevent further disability.

(b) ***Health teaching*** The nurse assists clients, families and groups to achieve satisfying and productive patterns of living through health teaching.

(c) ***Activities of daily living*** The nurse uses the activities of daily living in a goal directed way to foster adequate self-care and physical and mental well being of clients.

(d) ***Somatic therapies*** The nurse uses knowledge of somatic therapies and applies related clinical skills in working with clients.

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(e) *Therapeutic environment* The nurse provides, structures and maintains a therapeutic environment in collaboration with the client and other health care providers.

(f) *Psychotherapy* The nurse utilizes advanced clinical expertise in individual, group and family psychotherapy, child psychotherapy and other treatment modalities to function as a psychotherapist and recognizes professional accountability for nursing practice.

### *Standard VI: Evaluation*

The nurse evaluates client responses to nursing actions in order to revise the database, nursing diagnoses and nursing care plan.

### **Professional Performance Standards**

#### *Standard VII: Peer Review*

The nurse participates in peer review and other means of evaluation to assure quality of nursing care provided for clients.

#### *Standard VIII: Continuing Education*

The nurse assumes responsibility for continuing education and professional development and contributes to the professional growth of others.

#### *Standard IX: Interdisciplinary Collaboration*

The nurse collaborates with other health care providers in assessing, planning, implementing and evaluating programs and other mental health activities.

#### *Standard X: Utilization of Community Health Systems*

The nurse participates with other members of the community in assessing, planning, implementing and evaluating mental health services and community systems that include the promotion of the broad continuum of primary, secondary and tertiary prevention of mental illness.

### *Standard XI: Research*

The nurse contributes to nursing and the mental health field through innovations in theory and practice and participation in research.

## **GENERAL PRINCIPLES OF PSYCHIATRIC NURSING**

The following principles are general in nature and form guidelines for emotional care of a patient. These principles are based on the concept that each individual has an intrinsic worth and dignity and has potentialities to grow.

### **1. Patient is Accepted Exactly as He is**

Accepting means being non-judgmental. Acceptance conveys the feeling of being loved and cared. Acceptance does not mean complete permissiveness but setting of positive behaviors to convey to him the respect as an individual human being. A nurse should be able to convey to the patient that she may not approve everything what he does, but he will not be judged or rejected because of his behavior.

Acceptance is expressed in the following ways:

#### *(a) Being Non-judgmental and Non-punitive*

The patient's behavior is not judged as right or wrong, good or bad. Patient is not punished for his undesirable behavior. All direct (chaining, restraining, putting him in a separate room) and indirect (ignoring his presence or withdrawing attention) methods of punishment must be avoided. A nurse who shows acceptance does not reject the patient even when he behaves contrary to her expectations.

#### *(b) Being Sincerely Interested in the Patient*

Being sincerely interested in another individual means considering the other individual's interest.

This can be demonstrated by:

- Studying patient's behavior pattern.
- Allowing him to make his own choices and decisions as far as possible.
- Being aware of his likes and dislikes.

- Being honest with him.
- Taking time and energy to listen to what he is saying.
- Avoiding sensitive subjects and issues.

(c) *Recognizing and Reflecting on Feelings which Patient may Express*

When patient talks, it is not the content that is important to note, but the feeling behind the conversation, which has to be recognized and reflected.

(d) *Talking with a Purpose*

The nurse's conversation with a patient must revolve around his needs, wants and interests. Indirect approaches like reflection, open-ended questions, focusing on a point, presenting reality are more effective when the problems are not obvious.

Avoid evaluative, hostile, probing questions and use understanding responses, which may help the patient to explore his feelings.

(e) *Listening*

Listening is an active process. The nurse should take time and energy to listen to what the patient is saying. She must be a sympathetic listener and show genuine interest.

(f) *Permitting Patient to Express Strongly-held Feelings*

Strong emotions bottled up are potentially explosive and dangerous. It is better to permit the patient to express his strong feelings without disapproval or punishment. Expression of negative feelings (anxiety, fear, hostility and anger) may be encouraged in a verbal or symbolic manner. The nurse must accept the expression of patient's strong negative feelings quietly and calmly.

**2. Use Self-understanding as a Therapeutic Tool**

A psychiatric nurse should have a realistic self-concept and should be able to recognize one's

own feelings, attitudes and responses. Her ability to be aware and to accept her own strengths and limitations should help her to see the strengths and limitations in other people too. Self-understanding helps her to be assertive in life situations without being aggressive and feeling guilty.

**3. Consistency is used to Contribute to Patient's Security**

This means that there should be consistency in the attitude of the staff, ward routine and in defining the limitations placed on the patient.

**4. Reassurance should be given in a Subtle and Acceptable Manner**

Reassurance is building patient's confidence. To give reassurance, the nurse needs to understand and analyze the situation as to how it appears to the patient. False reassurance can also reflect a lack of interest and understanding or unwillingness on the part of the nurse to empathize with the patient's life situation.

**5. Patient's Behavior is Changed through Emotional Experience and not by Rational Interpretation**

Major focus in psychiatry is on feelings and not on the intellectual aspect. Advising or rationalizing with patients is not effective in changing behavior. Role-play and socio-drama are a few avenues of providing corrective emotional experiences to a patient and facilitating insight into his own behavior. Such experiences can truly bring about the desired behavioral changes.

**6. Unnecessary Increase in Patient's Anxiety should be Avoided**

The following approaches may increase the patient's anxiety and should, therefore, be avoided:

- Showing nurse's own anxiety.
- Showing attention to the patient's deficits.
- Making the patient to face repeated failures.
- Placing demands on patient which he obviously cannot meet.

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- Direct contradiction of patient's psychotic ideas.
- Passing sharp comments and showing indifference.

### 7. Objective Observation of Patient to Understand his Behavior

Objectivity is an ability to evaluate exactly what the patient wants to say and not mix up one's own feelings, opinion or judgment.

To be objective, the nurse should indulge in introspection and make sure that her own emotional needs do not take a precedence over patient's needs.

### 8. Maintain Realistic Nurse-Patient Relationship

Realistic or professional relationship focuses upon the personal and emotional needs of the patient and not on nurse's needs. To maintain professional relationship the nurse should have a realistic self-concept and should be able to empathize and understand the feelings of the patient and the meaning of behavior.

### 9. Avoid Physical and Verbal Force as Much as Possible

All methods of punishment must be avoided. If the nurse is an expert in predicting patient behavior, she can mostly prevent an onset of undesirable behavior.

### 10. Nursing Care is Centered on the Patient as a Person and not on the Control of Symptoms

Analysis and study of symptoms is necessary to reveal their meaning and their significance to the patient. Two patients showing the same symptoms may be expressing two different needs.

### 11. All Explanations of Procedures and other Routines are Given According to the Patient's Level of Understanding

The extent of explanation that can be given to a patient depends on his span of attention, level of

anxiety and level of ability to decide. But explanation should never be withheld on the basis that psychiatric patients are not having any contact with reality or have no ability to understand.

### 12. Many Procedures are Modified but Basic Principles Remain Unaltered

In psychiatric nursing field, many methods are adapted to individual needs of the patients, but the underlying nursing scientific principles remain the same. Some nursing principles to be kept in mind are: safety, comfort, privacy, maintaining therapeutic effectiveness, economy of time, energy and material.

### FUNCTIONS OF A PSYCHIATRIC NURSE

- Assessing the client and planning nursing care .
- Providing safe nursing care, including medication administration and participation in various therapies, individual interactions, formal and informal group situations, role-playing, advocating on behalf of the client, and so forth.
- Providing a safe environment, including protecting the client and others from injury.
- Accurately observing and documenting the client's behavior.
- Providing feedback to the client based on observations of his behavior.
- Teaching the client and significant others.
- Involving the client and the client's significant others in the nursing process.
- Providing opportunities for the client to make his own decisions and to assume responsibility for his emotions and life.
- Cooperating with other professionals in various aspects of the client's care; thereby, facilitating an interdisciplinary approach to care.
- Continuing nursing education and the exploration of new ideas, theories, and research.

### QUALITIES OF A PSYCHIATRIC NURSE

Certain attitudes are necessary for a psychiatric

nurse to deal with psychiatric patients. These include:

### **1. Self-awareness**

A Psychiatric nurse should have a realistic self concept and should be able to recognize her own feelings, fantasies and fears. She should analyze her own professional strengths and limitations. Her ability to be aware and to accept her own strengths and limitations should help her see the strengths and limitations in other people.

She should have her own beliefs and values related to life and should be able to acknowledge and accept her own feelings and their influence on her behavior.

She should have the ability to recognize when she is under stress and the influence of the stress on her physical and mental performance, and should be able to find ways to get adequate release from the stress.

Until the nurse is able to cope with personal fears and anxieties in relation to psychiatric nursing, it is unlikely that she can have a therapeutic influence in the patient's environment.

### **2. Self-acceptance**

The nurse should not only be aware, but also accept her strengths as well as her limitations. Self-understanding helps her to be assertive in life situations without being aggressive and feeling guilty.

### **3. Accepting the Patient**

Accepting means, being non-judgmental. Acceptance conveys the feeling of being loved and cared. The nurse should accept the patient as he is, as a sick person, regardless of caste, color, race or behavior.

The ability to talk therapeutically with patients requires an attitude of acceptance, tolerance and genuine interest in the patient. The basis of all helping relationships is acceptance which implies that the nurse treats the patient as an important person and not as a diagnostic entity or a set of psychiatric symptoms.

### **4. Being Sincerely Interested in Patient Care**

Being sincerely interested in patient care means considering the patients interest.

This can be demonstrated by:

- Studying patient's behavior pattern
- Allowing him to make his own choices and decisions as far as possible
- Being aware of his likes and dislikes
- Being honest with him
- Active listening.

### **5. Being Available**

Being available means nurse should be approachable all the time to the patient. She should convey to the patient that she is available not only to meet his physical needs, but also to assist him in dealing with his psychological needs.

### **6. Empathizing with the Patient**

Empathy is an important tool in understanding others' feelings. Empathy is a process when a person gets into another person's situation and experiences what the other person feels and then is able to step back and analyze the situation. The nurse need not necessarily have to experience it, but has to be able to imagine the feelings associated with the experience.

To be able to empathize with the patient the nurse must be willing to get involved enough to feel what the other person feels and at the same time avoiding over-involvement, projection of her own feelings and over-identification.

### **7. Reliability**

The nurse must demonstrate honesty, truthfulness, resourcefulness and competence in her dealings with the patients and their families. She must prove herself to be trustworthy and as a person who can be relied upon in any situation.

### **8. Professionalism**

Developing the professional skills of a psychiatric nurse is dependent upon learning as much as possible about the patient, his illness and the

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helping role of the nurse as it specifically applies to the patient.

### **9. Accountability**

According to Peplau (1980), the need for personal accountability and professional integrity are greater in psychiatric practice than in any other type of health care. Patients in mental health settings are usually more vulnerable and defenseless than patients in other health care settings, particularly because their conditions hinder their thinking processes and their relationships with others. Mental health nurses are accountable for the nature of the effort they make on behalf of patients and answerable to patients for the quality of their efforts.

### **10. The Ability to Think Critically**

The ability to think critically is crucial for mental health nurses. A critical thinker analyzes information before drawing conclusions about it. It is purposeful, reasonable, reflective thinking that drives problem solving and decision making and aims to make judgments based on evidence.

## **THERAPEUTIC ROLES OF A PSYCHIATRIC MENTAL HEALTH NURSE**

Psychiatric nurses have many roles that will continue to change and evolve as the health care environment changes. The roles of the nurse meet client and family needs, guide, assist, and teach the client and family; and provide an environment that facilitates client and family growth and development.

### **1. Direct Care Provider**

A Psychiatric nurse provides nursing care to individuals, families and groups to enable them to function at an optimal level of psychological wellness. As a direct care provider the nurse assists the client to regain health through the healing process. The nurse provides a holistic approach to care, including assisting the client/family in coping with the physical, emotional social and spiritual impacts of the illness.

### **2. Provider of Therapeutic Environment for the Patient**

The psychiatric nurse has always had a central role in maintaining a therapeutic environment. The nurse assesses potentially stressful characteristics of the environment and develops strategies to eliminate or decrease these stresses in the environment.

As protector the nurse helps maintain a safe environment for the client and takes steps to prevent injury and protect the client from possible adverse effects of diagnostic or treatment measures.

### **3. Teacher / Educator**

It is one of the primary intervention strategies the nurse uses in improving mental health.

Some topics that nurses address in their education include the following:

- Medication management
- Illness management
- Communication skills
- Coping skills
- Handling of stress and anxiety
- Dealing with emergencies

The teaching role requires skills to assess the patient's learning needs, level of learning ability and designing a teaching plan that encompasses cultural, socio-economic and personal needs.

Psychiatric nurses act as both advisors to people on health matters which are in essence teaching on a one-to-one basis, and engage in more formal teaching activities.

### **4. Coordinator**

Nurse as a coordinator, cooperates with other professionals in various aspects of the client's care; thereby facilitating an interdisciplinary approach to care.

The psychiatric nurse plans and supervises the care given by auxiliary nursing personnel. In addition, she consults with other professionals regarding the care given to the patient. She consults with the psychiatrist about his plan of treatment; she may need to talk with the

behavioral therapist about the psychological management, with the occupational therapist about his rehabilitation, with the social worker and the community agency about plans for his home care. In a nutshell, it is the nurse, who establishes a plan for the patient's care and serves as the coordinator for all activities concerned with him.

### 5. Patient Advocate

As the health care system has become more complex with a number of different agencies and an increasing variety of care providers concerned with different aspects of the patient's care, the need for someone who can speak on the patient's behalf and intercede in his interests has become essential. This speaking for the patient and interceding on his behalf is an important aspect of nursing care.

A patient needs at least one person to whom he can relate in a meaningful way and who can act as his spokesman with other members of health team. In this connection, the nurse is responsible for defining, defending and promoting the rights of the patient. A nurse is the logical person to interpret the different services offered by other professional health staff and to explain the types of and need for, various prescriptions and treatments as ordered by the physician. As an advocate, the nurse is compelled to work on behalf of the patient.

The advocacy role involves:

- Educating patients about their rights and responsibilities
- Negotiating for mental health services
- Reporting abuse of client's rights, unethical, incompetent and illegal practices
- Protecting the patient and family members from unethical practices.

### 6. Provider of Preventive Care

Preventive care includes health promotion, illness prevention, and protection against diseases.

The following activities are carried out by a psychiatric nurse for prevention of mental illnesses:

- Providing information about mental health issues, such as communication skills, parenting, stress reduction, coping strategies and relaxation techniques and counseling
- Making appropriate referrals as indicated to prevent occurrence of mental illness (primary prevention)
- Working with community groups on issues related to mental health
- Secondary prevention involves those nursing activities directed at reducing actual illness by early detection and treatment of the problem. Example: screening for anxiety and depression
- Tertiary prevention involves those nursing activities that focus on reducing the residual impairment or disability resulting from an illness.

### 7. Collaborator

As members of the health care team, nurses must work with other team members to ensure that patients receive the highest quality of care possible. In psychiatry, every patient must have an individualized treatment plan that reflects the collaborative efforts of nursing, psychiatry, social work, occupational therapy, recreational therapy and other specialties that are involved in the patient's care. Nurses can effectively work with other members of the health care team to deal with patient care problems.

### 8. Case Manager

In case management the nurse co-ordinates the activities of the other health care providers in collaboration with the direct care providers. The case manager focuses on moving the client through the health care environment, assisting with scheduling of tests and procedures and interacting with various care providers. Many times case managers follow a client across all settings, including ambulatory care and home care.

### 9. Professional Role

Nurses have a responsibility to contribute to the growth of self and of the profession. The nurse participates in continuing professional edu-

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tional activities and promotes activities designed to improve psychiatric nursing practice and care.

### **10. Researcher**

A Psychiatric nurse utilizes therapeutic principles and research to understand and interpret the client's emotions, thoughts and behaviors. She also involves in research activities to incorporate new research findings into practice and monitor the protection of human subjects.

### **REVIEW QUESTIONS**

- Historical development of psychiatric nursing (Nov 1999, Oct 2006)

- Scope of psychiatric nursing (Nov 2001, Oct 2002, Nov 2003)
- Current trends in mental health nursing (Nov 2002, Nov 2003, Oct 2006)
- Qualities of a psychiatric nurse
- Therapeutic roles of a psychiatric nurse
- Standards of mental health nursing (Nov 2001, Nov 2002)
- Principles of psychiatric nursing (Feb 2000, Feb 2001, Apr 2004, Oct 2004, Oct 2005, Apr 2006)
- Functions of psychiatric nurse
- Methods of psychiatric assessment (Nov 1999)

# 3

## Personality Development and Theories

- DEFINITION OF PERSONALITY
- PSYCHOSOCIAL FACTORS INFLUENCING PERSONALITY
  - Role of Heredity
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  - Psychoanalytic Theory
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  - Theory of Psychosocial Development
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  - Humanistic Approach
  - Trait and Type Theories of Personality
  - Behavior Theory

### DEFINITION OF PERSONALITY

"Personality refers to deeply ingrained patterns of behavior, which include the way one relates to, perceives, and thinks about the environment and one self".

[American Psychiatric Association (APA) 1987]

### PSYCHOSOCIAL FACTORS INFLUENCING PERSONALITY

#### I. Role of Heredity

At conception when the egg cell of the female is fertilized by the sperm cell of the male, each new human being receives a genetic inheritance that provides potentialities for development and behavioral traits throughout a lifetime.

The principal raw materials of personality – physique, intelligence and temperament are the result of heredity. How they will develop will depend on environmental influences. Many aspects of human behavior and development ranging from physical characteristics such as

height, weight, eye and skin color, the complex patterns of social and intellectual behavior, are influenced by a person's genetic endowment.

#### II. Environmental Factors

##### 1. Family

- Among environmental factors, the most important is the family environment. The reaction of the family environment towards an individual, and the role of parents, are very important in the molding of personality. Parents serve as a model whom the child imitates, and their influence is considerable on the child. Parents influence the development of a child's personality in a wide variety of ways. Children learn the moral values, code of conduct, social norms and methods of interacting with others from parents.
- On the whole friendly and tolerant fathers help children to have greater emotional stability and self confidence. Domineering and rigid fathers will only foster the development of submissive and frightened dependent children.
- Over-protective mothers will influence children in the direction of dependence and a total disregard for others. Nagging mothers will cause children to be shy, submissive and emotionally unstable.
- Besides the role of the parents, the atmosphere in the family is greatly influencing. A peaceful and loving atmosphere results in children being orderly, peace-loving and very affectionate. Without undue strain they develop

mature and pleasant personalities. In a family where there is tension, constant quarrels and incompatibility among parents, the child is likely to develop strong feelings of insecurity and inferiority.

- Birth order: This is another familial factor that can have an important influence on personality development. Every child has a unique position in the family, such as the eldest, youngest, second or third. This position has a definite influence on personality. The eldest child is very often overburdened with responsibility, hence he grows up to be very independent, while the youngest being the baby of the family is petted and spoilt. The common view of an only child would be that he will be pampered and spoilt.

### 2. *Physique*

An individual's size, strength and general appearance determines to a large extent the way in which he behaves towards others and how others react towards him. An individual with an imposing body-build and a healthy appearance definitely influences those around him. Even if he has not proved himself, yet he gains recognition and status through his physical appearance. Contrary to this is the small lean person; even if he has some merits, these are over-looked because of his physique. People are apt to judge him according to his appearance.

### 3. *Endocrine Glands*

- The secretions of endocrine glands affect physical growth, emotional growth and mental growth. These will have an impact on the total personality of an individual.
- The thyroid gland secretes a hormone called thyroxin, and the main function of this hormone is regulation of body metabolism. If the thyroid gland is under-active, the result is usually mental dullness, inactivity, depression, fatigue and poor appetite. Hypersecretion of these glands leads to extreme over-activity.

- The parathyroid gland regulates calcium metabolism. Excitability of the nervous system is directly dependent on the amount of calcium in the blood. Deficient working of this gland leads to the development of an irritable, distracted, nervous and a tense person.
- Similarly other glands namely pituitary, the adrenal and the gonads have their tremendous impact on various personality traits.

### 4. *School*

- The children spend much of their time in the schools and hence it can play a very large part in the formation of the personality of the child.
- The following factors of school will have direct role on child personality:
  - the friendships and acquaintances which are made among the children themselves
  - the type of curriculum in the schools, which affects the habitual responses of children
  - well-furnished laboratories, adequate playground, etc.

A nurturant school atmosphere that provides for all-round development, consistency, structure, warmth and responsiveness, can do a great deal to help children develop a favorable personality and cope with changing life circumstances.

### 5. *Teacher*

A teacher is the most important person in the school who can help in modifying children's personalities. He is the most powerful source of stimulation for the child. If he/she possesses desirable personal and social modes or reactions, he will inculcate them among his students. On the other hand, effects of prejudicial treatment on the part of teachers can make the child lose self-confidence and develop low self-esteem.

### 6. *Peer Group*

Developmental psychologists believe that interactions with peers are critical to many of the social

skills and advances that occur during childhood.

Peer group refers to other children of the same age who study with or play with the child. Peer group is much more influential than siblings or parents.

Even at preschool age, playmates are highly influential. Children imitate peers and try to be like them in many respects. The peer group serves as an important reference group in shaping personality traits and characteristics of the growing child. As the child grows up peers become progressively more influential in molding the child's self concept. Children learn many forms of behavior, some socially appropriate and others socially undesirable, from their peers.

For example, by striving to be accepted and liked by their peers, they gain new insights into the meaning of friendship. Through give and take with peers, they learn the importance of sharing, reciprocity and cooperation. By trying to get peers to understand their thoughts and feelings, they learn to communicate more effectively. Within the peer group, children also learn sex-role norms. In general, boys become rougher, boisterous, more compulsive, and form larger groups, while girls tend to form more intimate, more exclusive groups. Feelings of masculine superiority, sex bias and other attitudes and behavior develop with gender identification.

### *7. Sibling Relationships*

The number of siblings as well as their sex and age has a considerable influence on the development of both favorable and unfavorable personality traits like cooperativeness, sharing, aggressiveness, jealousy, etc. Although sibling rivalry is common, older siblings invariably teach the infant a great deal and they can even function as a source of security. On the other hand, unhealthy comparisons can also develop, for instance, an athletic child who is favored by an athletic father over a less active sibling, may suffer from an inferiority complex or develop low self-esteem.

### *8. Mass Media*

Mass media includes films, television, radio, printed literature, etc. Mass media has a considerable impact on attitudes, values, beliefs and behavior patterns. Baron and Bryne (1986) have shown that individuals, especially children, imitate specific aggressive acts of models. They have proposed that human personality formation is a result of modeling and imitating the behavior of significant others. Many abnormal forms of behavior can be learned by imitating models from the mass media.

### *9. Culture*

Culture influences personality because every culture has a set of ethical and moral values, beliefs and norms which considerably shapes behavior. Cross-cultural studies have pointed out the importance of cultural environment in shaping our personality. Individuals of certain cultures are more generous, open-hearted and warm whereas individuals of some other cultures are suspicious, introverted and self-centered. It has also been found that certain cultural communities are more prone to develop certain abnormal behaviors as compared to others, probably due to the influence of geographical, dietary, hormonal or genetic influences within the community.

## **DEVELOPMENT OF PERSONALITY**

"Personality consists of distinctive patterns of behavior (including thoughts and emotions) that characterize each individual's adaptation to the situations of his or her life".

(Walter Mischel, 1976)

### **Babyhood (Birth – 2 years of life)**

- This period is the true foundation period of life because many behavioral patterns, attitudes and patterns of emotional expressions are being established. These have a lifelong influence on the child's personal and social adjustments.

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- The term 'infant' suggests extreme helplessness. The infant is truly a dependent individual, and his total existence depends on resources outside himself. It is a time of rapid growth and development, and a time of radical adjustments.
- An average infant weighs 7 lbs and measures 18-19 inches in length. Common responses like spontaneous eye movements, yawning, turning and lifting the head, etc. are present. Gradually dentition, bowel and bladder control develop. The baby grows rapidly and masters some common skills such as self-feeding, self-dressing, walking alone, climbing stairs, etc.
- The baby's vocalization includes crying, cooing, gurgling, which gradually develop into babbling, and later, speech.
- Emotional reactions are intense and sudden, whatever the stimulus. These reactions may be described as states of pleasantness (characterized by relaxing of the body) and unpleasantness (characterized by tensing of the body). Later on, emotions such as anger, fear, curiosity, joy, affection are exhibited. Babies who experience more of pleasant emotions are laying the foundation for good personal and social adjustments later on in life.
- **Personality traits**

Children are born with characteristic temperamental differences, and it is these differences from which the individual personality patterns develop. The infant develops self-trust by trusting in what he sees and hears. The beginning feelings of confidence and faith develop if he receives what is needed. Feelings of distrust develop if the baby's needs are not met. This leads to personality problems such as clinging and demanding behavior, greed, giving up easily, taking rather than giving, etc.

### **Early Childhood (2-6 years)**

Growth during early childhood proceeds at a slow rate as compared with the rapid rate of

growth in infancy. Body proportions change markedly. The muscles become longer, stronger and heavier. The average annual increase in height is 3 inches and the average annual increase in weight is 3-5 lbs.

Emotions are especially intense, and they are easily aroused to emotional outbursts such as temper tantrums, fears, and unreasonable outbursts of jealousy. Other emotions of curiosity, joy, and affection also develop.

### **Personality Traits**

- The most important psychosocial achievement at this time is the development of autonomy or independence. If trust and security do not develop at an early age, autonomy will fail to develop. There is heightened awareness and curiosity of the self, termed as narcissism. The issue of sexuality also overtly develops.
- The child also begins to know the difference between right and wrong, and laid down standards of behavior and rules of conscience which will thereafter guide much of his behavior.
- In this phase specific crisis is between initiative and guilt. If the child successfully passes through this stage, it leads to internalization of values and social sanctions, and from this time onwards, he is able to differentiate between right and wrong and to lay down standards of behavior and rules of conscience that will thereafter guide much of his behavior.
- The child with faulty autonomy traits will be clinging and dependent. Phase related adult characteristics include stubbornness, over compensatory control, compulsive cleanliness and extreme self control. He may also develop intense anxiety or guilt or an antisocial personality.

### **Late Childhood (6-11 years)**

- Late childhood is a period of slow and uniform growth. The average annual increase in height

is 2-3 inches, and the average annual weight increase is 3-5 lbs.

- Emotional expressions are usually pleasant ones, although outbursts of anger, anxiety and frustration may continue to occur.

#### *Psychosocial Development*

- It is during this stage there is increased ego control over basic drives. Behavioral characteristics like sympathy and concern for others, cleanliness, modesty, co-operation and willingness to share develop. The child now looks beyond the family and begins to interact with the social system.
- Developmental tasks during this period are the acquisition of social skills, incorporating social values and patterns, and competition and interaction with peers and authority figures. Failure in mastery of the tasks results in emotional instability, low self-esteem, social inferiority and inability to assume expected responsibilities.

#### **Adolescence (12-19 years)**

- The period of adolescence is a period of "storm and stress," an action-oriented phase of life in which feelings and thoughts are primarily expressed through behavior.
- The important physical changes which occur during this period include changes in body size and proportion, and the development of primary and secondary sex characteristics.

#### *Psychosocial Development*

- A major change from the childhood to the adolescent is the development of self-consciousness. Adolescents become very aware of how others see them and react to them, and this awareness makes teenagers feel apprehensive and extremely self-conscious.
- This is the period when there is a consolidation of personality and a beginning sense of identity as a mature person. Phase specific tasks for the adolescent may be identified as gaining independence from the family, integrating new found sexual maturity,

establishing meaningful relationships with peers of both sexes, and making decisions about life work and goals.

- Parent-adolescent conflict is very common, as adolescents seek independence from their parents. The approval of their own age group is much more important to them than the approval of adults. Intense conflicts can occur if the values of the group conflict with those of the parents. Being a member of the peer group has a strong influence on the self-identity and self-esteem of the adolescent.
- The issues of the period of later adolescence (15-19 years) are related to career, marriage and parenthood. This is the period when there is a consolidation of the personality and a beginning sense of identity as a mature person.
- Characteristic troubles of the adolescent identity crisis may include psychosis, neurosis, delinquency (breaking rules of society), etc.

#### **Early Adulthood (20-40 years)**

- The term 'adult' is derived from the Latin word '*adultus*', which means 'grown to full size and strength'. Adults are therefore individuals who have completed their growth and are ready to assume their status in society along with other adults.
- During this stage, the physical and psychological changes which accompany the beginning of reproductive capacity appear. The Basal Metabolic Rate (BMR) slowly begins to come down, when compared to adolescence, so excess body weight is easily gained.

#### *Psychosocial Development*

- The four major social expectations or tasks for the adult include choice of career, sexual mutuality (marriage / choosing a life partner), generativity and child-rearing, participation in social processes and work.
- If the young adult has been over-protected by parents, difficulties arise in forming intimate relationships with another person and coping with responsibilities in the working world.

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### Middle Adulthood (41-60 years)

Physical changes related to ageing become more prominent, such as wrinkled skin, muscular pains and impaired sensory capacities. Faulty lifestyles may bring on diseases such as hypertension, heart disease, cancer, etc. A very major physical change is menopause or the male climacteric. Many physical discomforts and mood changes may accompany menopause, and they may become depressed, hostile and self-critical and have wide mood swings. All these usually disappear once endocrine balance is restored. How successfully women make the adjustment to the physical and psychological changes that accompany menopause is greatly influenced by their past experiences, and especially the social support available to them.

#### Psychosocial Issues

- During this age, people become more and more occupied with their work and family. The major adjustments to be made during this period include adjusting to physical and mental changes, occupational responsibilities, approaching retirement and old age.
- Failure to master these developmental tasks may lead to marital, social or occupational conflicts and failures.

### Late Adulthood (Old age – 60 years and above)

- Physical changes include wrinkling of skin, stooped posture, flabbiness of muscles, decreased vision and hearing, a decreased efficiency of cardiovascular system
- Psychosocial issues
- The theme of this age period is loss, which may be identified as follows:
  - Loss of physical abilities
  - Loss of intellectual processes
  - Loss of work role and occupational identification (retirement)
  - Loss of intimate ties, such as death of spouse, friends and other acquaintances
- The major adjustments to be made include adjustment to physical changes, retirement,

loss of spouse, post-child rearing period (empty nest syndrome), grandparenthood

- If favorable factors such as satisfaction of needs, retention of old friendships, positive social attitudes, etc. are present, they foster ego integrity of the person. However without adequate support to sustain and bear the losses the older adult is vulnerable to a profound sense of insecurity. Despair and disgust can take over the person, including the feeling, time is running out and there are no alternatives possible at this late date.
- Serious personality breakdown in old age may lead to criminal behavior or suicidal tendencies, as in dementia.

### THEORIES OF PERSONALITY DEVELOPMENT

Developmental theories identify behaviors associated with various stages through which individuals pass, thereby specifying what is appropriate or inappropriate at each developmental level. Nurses must have a basic knowledge of human personality development to understand maladaptive behavioral responses commonly seen in the mentally ill. Knowledge of the appropriateness of behavior at each developmental level is vital to the planning and implementation of quality nursing care.

#### Psychoanalytic Theory

Freud (1939), who has been called the father of psychiatry, is credited as the first to identify development by stages. He believed that an individual's basic character is formed by age 5. Freud categorized his personality theory according to structure, dynamics, and development.

##### *Structure of the Personality*

Freud organized the structure of personality into three major components : the id, ego, and superego.

##### *Id*

The id contains all our biologically based drives – the urge to eat, drink, eliminate, and especially,

to be sexually stimulated. The sexual energy that underlies these urges is called the libido. The id operates according to the “pleasure principle.” That is, it desires to satisfy its urges immediately, without regard to rules, realities of life or morals of any kind. Id present at birth, it endows the infant with instinctual drives that seek to satisfy needs and achieve immediate gratification. Id driven behaviors are impulsive and may be irrational.

### *Ego*

The ego functions on the basis of “reality principle”, and begins to develop between ages 4 and 6 months. The ego experiences the reality of the external world, adapts to it, and responds to it. It delays satisfying id, and channels our behavior into socially acceptable way. A primary function of the ego is that of mediator, that is to maintain harmony between the external world, the id, and the superego.

### *Superego*

The superego is referred to as the “perfection principle” or the “moral principle”. The superego which develops between ages 3 and 6, internalizes the values and morals set forth by primary caregivers. The superego is important in the socialization of the individual as it assists the ego in the control of id impulses. When the superego becomes rigid and punitive, problems with low self-confidence and low self-esteem arise.

### *Dynamics of the Personality*

- Freud believed that “psychic energy” is the force or impetus required for mental functioning. Originating in the id, it instinctually fulfills basic physiological needs. As the child matures, psychic energy is diverted from the id to form the ego and then from the ego to form the superego.
- Psychic energy is distributed within these three personality components, largest share to maintain a balance within impulsive behavior of id and the idealistic behavior of

the superego. If an excessive amount of psychic energy is stored in one of these personality components, behavior will reflect that part of the personality. For instance, impulsive behavior will prevail when excessive psychic energy is stored in the id.

- Overinvestment in the ego will reflect self-absorbed or narcissistic behaviors and an excess within the superego will result in rigid, self-deprecating behaviors.
- The human personality functions on three levels of awareness: conscious, preconscious and unconscious.
- Consciousness refers to the perception, thoughts and feelings existing in a person’s immediate awareness.
- Preconscious content on the other hand, is not immediately accessible to awareness. Unlike conscious and preconscious, content in the unconscious remain inaccessible for the most part.
- The unconscious affects all the three personality structures – id, ego and the superego. Although the id’s content resides totally in the unconscious, the superego and the ego have aspects in all the three levels of consciousness.
- Some ideas, memories, feelings or motives which are disturbing, forbidden, and unacceptable and anxiety producing are repressed from consciousness. The process of repression itself is unconscious and automatic, it just happens without our knowledge. This repressed material continues to operate underground and converts the repressed conflicts into disturbed behavior and unexplained signs and symptoms. According to Freud this repressed material is also responsible for some of our dreams, accidental slips of tongue, etc.

### *Freud's Stages of Personality Development*

Freud described formation of personality through five stages of psychosexual development. Freud placed much emphasis on the first 5 years of life and believed that characteristics developed

during these early years bore heavily on one's adaptation patterns and personality traits in adulthood. Fixation in an early stage of development will almost certainly result in psychopathology.

### 1. Oral stage: Birth to 18 months

The major developmental tasks during this stage are "relief from anxiety through oral gratification of needs". During this stage behavior is directed by the id. The focus of energy is the mouth. The baby obtains pleasure from sucking, biting, and chewing. The infant feels a sense of attachment and is unable to differentiate the self from the person who is providing the mothering. At the age of 4-6 months the development of ego will begin, the infant starts to view the self as separate from the mothering figure. A sense of security and the ability to trust others is derived out of gratification from fulfillment of basic needs during this stage.

### 2. Anal stage : 18 months to 3 years

The major developmental tasks in this stage are gaining independence and control, with focus on the excretory function. During this stage the id is slowly brought under the control of ego. Freud believed that the manner in which the parents and other primary caregivers approach the task of toilet training may have long term effects on the child in terms of values and personality characteristics. When toilet training is strict and rigid, the child may choose to retain the feces, becoming constipated. Adult retentive personality traits influenced by this type of training include stubbornness, stinginess and miserliness.

Toilet training that is more permissive and accepting attaches the feeling of importance and desirability to feces production. The child becomes extroverted, productive and altruistic.

### 3. Phallic stage : 3 to 6 years

The major developmental task during this stage is identification with parents of the same sex and development of sexual identity; focus is on genital

organs. The development of Oedipus complex occurs during this stage of development. Freud described this as the child's unconscious desire to eliminate the parent of the same sex and to possess the parent of the opposite sex. Guilt feelings result with the emergence of the superego during these years. Resolution of this internal conflict occurs when the child develops a strong identification with the parent of the same sex and that parent's attitudes, beliefs and value system are subsumed by the child.

### 4. Latency stage: 6 to 12 years

The major developmental task during this stage is "repressed sexuality with focus on relationships with same sex peers". Sexuality is not absent during this period, but remains obscure and imperceptible to others. Children of this age show a distinct preference for same-sex relationships, even rejecting members of the opposite sex.

### 5. Genital stage: 13 to 20 years

The major developmental tasks during this stage are: Libido is reawakened as genital organs mature; focus is on relationships with members of the opposite sex. The development of sexual maturity evolves from self-gratification to behaviors that have been deemed acceptable by societal norms.

### Interpersonal Theory

Sullivan (1953) believed that an individual's behavior and personality development are the direct result of interpersonal relationships and that personality development is determined within the context of interactions with other humans.

Sullivan's major concepts include:

#### 1. Anxiety

A central theme of Sullivan's theory is anxiety and its relationship to the formation of personality. He viewed anxiety as a primary motivator of behavior, a builder of self-esteem and the great educator in life. It arises out of

one's inability to satisfy needs or achieve interpersonal security. He also believed that anxiety is the chief disruptive force in the development of serious difficulties in living.

## 2. The self system

It is a significant aspect of the personality that develops in response to anxiety. Disapproving and forbidding gestures during interactions with significant others help to develop the self-system. Sullivan identified three components of the self-system, which are based upon interpersonal experiences early in life.

- A. The "good me" – the part of the personality that develops in response to positive feedback from the primary caregiver. Feelings of pleasure and gratification are experienced.
- B. The "bad me" – part of the personality that develops in response to negative feedback from the primary caregiver and experiences related to increased anxiety states. Feelings of discomfort and distress are experienced.
- C. The "not me" – the part of the personality that develops in response to situations that produce intense anxiety in the child. Feelings of horror and dread are experienced. The child may develop emotional withdrawal.

## 3. Security operations

Security operations become a part of the self system to help the individual avoid or minimize anxiety. The security operations include sublimation, selective inattention and dissociation.

- Sublimation is an unconscious process of substituting a socially acceptable activity pattern to partially satisfy a need for an activity that would give rise to anxiety.
- Selective inattention is an unconscious substitute process that allows many meaningful details of one's life that are associated with anxiety to go unnoticed.
- Dissociation is a system of process that minimizes or avoids anxiety by keeping parts of the individual's experiences called 'not me' out of consciousness.

## *Sullivan's Stages of Personality Development*

Sullivan described six stages of personality development from birth to maturity, which he divided according to the capacity for communication and integration of new interpersonal experiences. Experiences during each stage are influenced by those of the previous one. The personality achieves some degree of stability at the end of the juvenile era (see below), but continues to develop beyond this time and has the potential for corrective experiences.

### *1. Infancy: Birth to 18 months*

The major developmental task during this stage is "relief from anxiety through oral gratification of needs". This is accomplished around activity associated with the mouth, such as crying and thumb sucking.

### *2. Childhood: 18 months to 6 years*

The major developmental task during this stage is "learning to experience a delay in personal gratification without undo anxiety". Tools of this stage include the mouth, language, the anus, experimentation, manipulation, and identification.

### *3. Juvenile: 6 to 9 years*

The major developmental task during this stage is "learning to form satisfactory peer relationships". This is accomplished through the use of competition, co-operation and compromise.

### *4. Preadolescence: 9 to 12 years*

The major developmental task during this stage is "learning to form satisfactory relationships with persons of same sex"; the initiation of feelings of affection for another person.

### *5. Early adolescence: 12 to 14 years*

The major developmental task during this stage is "learning to form satisfactory relationship with persons of the opposite sex; developing a sense of identity". The emergence of lust in response to

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biological changes is a major force occurring during this period.

### 6. Late adolescence: 14 to 21 years

The major developmental task during this stage is "establishing self identity; experiencing satisfying relationship; working to develop a lasting, intimate opposite-sex relationship." The genital organs are the major developmental focus of this stage.

### Theory of Psychosocial Development

Erikson (1963) studied the influence of social processes on the development of the personality. Erikson tried to revise psychoanalytic theory by giving a greater role to ego processes. He expanded Freud's theory to cover the whole life cycle of man as the Eight Stages of Man. At each of these 8 stages, the individual is faced with a psychosocial crisis, which must be successfully resolved, if healthy development must take place at a later stage.

#### 1. Infancy (0 – 1 year) Trust vs Mistrust

- The major developmental task during this stage is "to develop a basic trust in the mothering figure and be able to generalize it to others".
- The infant learns to trust if all his needs are met. Achievement of the task results in self confidence, optimism and faith in the

gratification of needs and desires and hope for the future.

- Distrust can develop if the infant's world is filled with insecurity due to unmet needs, caused by lack of caring on the part of parents and significant others.
- Non-achievement results in emotional dissatisfaction with the self and others, suspiciousness, and difficulty with interpersonal relationship.

#### 2. Early Childhood (2 – 3 years) – Autonomy vs Shame and Doubt

- The major developmental task during this stage is "to gain some self-control and independence within the environment".
- As the child attempts to gain independence, parents need to encourage him, which will help him gain autonomy. Achievement of the task results in a sense of self-control and the ability to delay gratification, and a feeling of self-confidence in one's ability to perform.
- If he is not allowed freedom or if he is overprotected or criticized for what he does, shame, doubt and uncertainty about himself and his capabilities will result.

#### 3. Middle Childhood (4 to 5 years) – Initiative vs Guilt

- The major developmental task during this stage is "to develop a sense of purpose and

| St.No. | Stage  | Psychosocial Crisis            | Virtue     |
|--------|--|--------------------------------|------------|
| 1      | Infancy (Birth to 1 year)                      | Basic Trust vs Mistrust        | Hope       |
| 2      | Early Childhood (2-3 years)                    | Autonomy vs Shame and Doubt    | Will power |
| 3      | Middle Childhood (4-5 years)                   | Initiative vs Guilt            | Purpose    |
| 4      | Late Childhood (6-11 years)                    | Industry vs Inferiority        | Competence |
| 5      | Adolescence (12-19 years)                      | Ego Identity vs Role Confusion | Fidelity   |
| 6      | Early Adulthood (20-25 years)                  | Intimacy vs Isolation          | Love       |
| 7      | Middle Adulthood (26-64 years)                 | Generativity vs Stagnation     | Care       |
| 8      | Late Adulthood or Old Age (65 years and above) | Ego Integrity vs Despair       | Wisdom     |

- the ability to initiate and direct own activities.
  - Initiative is achieved when creativity is encouraged and performance is recognized and positively reinforced.
  - Achievement of the task results in the ability to exercise restraint and self-control of inappropriate social behaviors.
  - If his initiative and curiosity are discouraged, the child may be prevented from setting future goals by a sense of guilt and shame for holding such ambitions.
- 4. Late Childhood (6 – 11 years) – Industry vs Inferiority**
- The major developmental task during this stage is “to achieve a sense of self-confidence by learning, competing, performing successfully, and receiving recognition from significant others, peers and acquaintances.
  - If parents praise the children’s efforts, a sense of esteem and industry develops. Achievement of the task results in a sense of satisfaction and pleasure in the interaction and involvement with others.
  - When parents set unrealistic expectations for the child, when discipline is harsh and tends to impair self esteem, and when accomplishments are consistently met with negative feedback, the individual may become a workaholic with unrealistic expectations, non-achievement results in difficulty in interpersonal relationships due to feelings of personal inadequacy.
- 5. Adolescence (12 – 19 years) – Ego Identity vs Role Confusion**
- The major developmental task during this stage is “to integrate the tasks mastered in the previous stages into a secure sense of self”. Childhood comes to an end during this stage and youth begins. Puberty brings on a “physiological revolution” with which adolescents must learn to cope.
  - Identity is achieved when adolescents are allowed to experience independence by making decisions that influence their lives.

Achievement of the task results in a sense of confidence, emotional stability, and a view of the self as a unique individual.

- When independence is discouraged by the parents, and the adolescent is nurtured in the dependent position, it may cause a lack of self-confidence. Non-achievement results in a sense of self-consciousness, doubt and confusion about one’s role in life.

**6. Early Adulthood (20 – 25 years) – Intimacy vs Isolation**

- The major developmental task during this stage is “to form an intense, lasting relationship or a commitment to another person”.
- Intimacy is achieved when an individual has developed the capacity for giving of oneself to another. This is learned when one has been the recipient of this type of giving within the family unit. Achievement of the task results in the capacity for mutual love and respect between two people.
- If there is extreme fear of being rejected or disappointed, the individual may withdraw or isolate himself.

**7. Middle Adulthood (26-64 years) – Generativity vs Stagnation**

- The major developmental task during this stage is “to achieve the life goals established for oneself, while also considering the welfare of future generations.
- For Erikson, generativity includes marriage, parenthood and the sense of working productively for the good of others.
- The generative individual enjoys work and family and is continuously ready to come to the aid of others.
- When earlier developmental tasks are not fulfilled he becomes withdrawn, isolated, and highly self-indulgent.

**8. Old age (65 years and above) – Ego integrity vs Despair**

- The major developmental task during this stage is “to review one’s life and derive

meaning from both positive and negative events, while achieving a positive sense of self-worth".

- Ego integrity is achieved when individuals have successfully completed the developmental tasks of the previous stages.
- Achievement of the task results in a sense of self-worth and self-acceptance.
- When earlier tasks are unresolved he feels worthless and helpless to change. Non-achievement results in a sense of self-contempt and disgust with how life has progressed.

### Cognitive Development Theory

- Jean Piaget (1896-1980) a Swiss philosopher and psychologist dedicated his life work to observing and interacting with children to determine how their thinking processes differed from adults.
- According to Piaget's theory of personality development, the developing child passes through four main discrete stages: the sensorimotor stage, the preoperational stage, the stage of concrete operations, and the stage of formal operations. Each stage reflects a range of organizational patterns that occur in definite sequence and within an approximate age span.
- Development is influenced by biological maturation, social experiences, and experiences with the physical environment. During cognitive development the individual strives to find equilibrium between self and environment.
- Cognitive theory explains how thought processes are structured, how they develop and their influence on behavior. Structuring of thought processes occurs through the development of schema (i.e. mental images or cognitive structures). Thought processes develop through assimilation and accommodation. When the child encounters new information that is recognized and understood within existing schema, assimilation of that new information occurs. If new information

cannot be linked to existing schema, the child must learn to develop new mental images or patterns through the process of accommodation. As long as the child is able to assimilate or accommodate adequately to new knowledge, the child is able to achieve equilibrium or mental balance. When schemas are inadequate to facilitate learning, disequilibrium may occur.

### *Major Cognitive Development Stages*

#### *Stage I: Sensorimotor (Birth to 2 years)*

- The major developmental tasks during this stage are increased mobility and awareness, developing a sense of self as separate from the external environment.
- During this stage the child is concerned only with satisfying basic needs and comforts.
- The child develops a greater understanding regarding objects within the external environment and their effects upon him or her. Knowledge is gained regarding the ability to manipulate objects and experiences within the environment.

#### *Stage II: Preoperational (2 to 6 years)*

- The major developmental tasks during this stage are "Learning to express self with language, develops understanding of symbolic gestures, achievement of object permanence".
- Uses language and can represent objects by images and words.
- Remains egocentric: Unable to think from another's point of view. Cannot distinguish reality from fantasy.
- Acquires language: Only intuitively guesses about cause and effect.

#### *Stage III: Concrete operations (6 to 12 years)*

- The major developmental tasks during this stage are: learning to apply logic to thinking; develops understanding of reversibility and spatiality; learning to differentiate and classify.

- Able to think about past and present events but not future. The child is able to acknowledge the viewpoints of others and appreciate feelings.

*Stage IV: Formal operations period (12 to 15 years)*

- The major developmental tasks during this stage are: learning to think and reason in abstract terms; makes and tests hypotheses.
- Logical thinking and reasoning ability expand and are refined.
- Can think of future events and develops strategies for solving complex problems. Cognitive maturity is achieved during this stage.

### Theory of Moral Development

- Moral development encompasses moral judgment or reasoning processes and involves making decisions about right or wrong actions in a particular situation (Stroufe, Cooper and Dettart, 1992).
- Piaget examined the concept of moral development; according to him moral judgment is first based on consequences and later on motives.
- Lawrence Kohlberg built on Piaget's work in the area of moral development. Kohlberg believes that each stage is necessary and basic to the next stage and that all individuals must progress through each stage sequentially. He defined three major levels of moral development.

#### *Level I: Pre-conventional Level*

(Self-centered orientation – Ages 4 to 10 years)

This stage consists of 3 substages:

##### *1. Egocentric judgment:*

In which children make decisions based on what they like or wish with no obligations to obey authority figures.

##### *2. Punishment and obedience orientation:*

Moral decisions are based on avoidance of punishment. Children realize that there are physical consequences in the form of punishment for bad behaviors. In this stage, children learn the

authority role; the child is responsive to cultural guidelines of good and bad, right and wrong, but primarily in terms of the known related consequences.

##### *3. Instrumental relativist orientation*

During this stage moral decisions are motivated by desire for rewards rather than avoiding punishment, and belief that by helping others they will get help in return. Behaviors of this stage are guided by egocentrism and concern for self. There is an intense desire to satisfy one's own needs, but occasionally the needs of others are considered.

#### *Level II: Conventional Level*

(Able to see victim's perspective-ages 10 to 13 years)

##### *4. Interpersonal concordance orientation*

Moral decisions are based on desire for approval from others and on avoiding guilt experienced by not doing the right thing. Behavior at this stage is guided by the expectations of others.

##### *5. Law and order orientation:*

In this stage moral decisions are defined by rights, assigned duty, rules of the community and respect for authority.

#### *Level III: Post-conventional Level*

(Underlying ethical principles are considered that take into account societal needs – Ages 13 years and above)

##### *6. Social contract legalistic orientation:*

Moral decisions are based on a sense of community respect and disrespect. This stage focuses on the legal point of view but is also open to considering what is moral and good for society. Individuals who reach this stage have developed a system of values and principles that determine for them what is right or wrong.

##### *7. Universal ethical principle orientation:*

This stage deals with abstract and ethical moral values, rather than concrete moral rules. These include universal principles such as equality,

justice and beneficence. Behavior is motivated by internalized principles of honor, justice, and respect for human dignity and guided by the conscience.

### Humanistic Approach

In contrast to the pessimism of the psycho-dynamic perspective, the humanistic approach optimistically argues that people have enormous potential for personal growth. When personality development focuses upon the development of self, it is called humanism. Humanists like Carl Rogers and Abraham Maslow reject the internal conflicts of Freud's view and the mechanistic nature of behaviorism. They believe that each person is creative and responsible, free to choose and each strives for fulfillment or self actualization.

Humanistic theories emphasize the importance of people's subjective attitudes, feelings, and beliefs, especially with regard to the self. Carl Rogers's theory focuses on the impact of disparity between a person's ideals, self and perceived real self. Maslow focuses on the significance of self actualization.

### Rogers' Person-Centered Approach

Rogers' emphasized that each of us interprets the same set of stimuli differently, so there are as many different 'real worlds' as there are people on this planet. (Rogers, 1980)

### Self-Actualization

Carl Rogers used the term self-actualization to capture the natural, underlying the tendency of humans to move forward and fulfill their true potential. He argued that people strive towards growth, even in less-than favorable surroundings.

### Personality Development

Carl Rogers proposed that even young children need to be highly regarded by other people. Children also need positive self regard to be esteemed by self as well as others. Rogers believed that everyone should be given unconditional positive regard, which is a nonjudgmental and genuine love, without any strings attached.

### Maslow's Hierarchy of Needs

- Maslow proposed that our human motives are arranged in a hierarchy, with the most basic needs at the bottom. At the top are the more highly developed needs like self esteem needs and finally self-actualization.
- Maslow's hierarchy proposes that our needs must be fulfilled in a specified order, from physiological, safety, and love to the higher needs of esteem and self actualization; Maslow also specified a list of characteristics descriptive of self-actualized people.
- One of the basic themes underlying Maslow's theory is that motivation affects the person as a whole, rather than just in part. Maslow believed that people are motivated to seek personal goals which make their lives rewarding and meaningful.
- Abraham Maslow suggested that 5 basic classes of needs or motives influence human behavior. According to Maslow, needs at the lowest level of the hierarchy must be satisfied before people can be motivated by higher-level goals.

### Schematic Representation of Maslow's Hierarchy of Needs



From the bottom to the top of the hierarchy, the five levels of motives according to Maslow are:

### **Physiological Needs**

The physiological needs are most basic, powerful and urgent of all human needs that are essential to physical survival. Even if one of these needs remains unsatisfied the individual rapidly becomes dominated by it, so all other needs become secondary. Included in this group are the need for food, water, oxygen, sex, activity and sleep.

### **Safety and Security Needs**

Once the physiological needs are fairly well-satisfied, safety and security needs predominate. Included here are the needs for structure, stability, law and order, and freedom from such threatening forces as illness and fear.

### **Love and Belongingness Needs**

These needs become prominent when the physiological and safety/security needs have been met. The person at this level longs for affectionate relationship with others, for a place in his family and social groups. Accordingly a person experiences feelings of loneliness, friendlessness and rejection, especially when caused by the absence of friends and loved ones.

### **Self-Esteem Needs**

Maslow divided these needs into two types: Self respect and respect from others. Self-respect includes a person's desire for competence, confidence, achievement and independence. Respect from others includes his desire for prestige, reputation, status, recognition, appreciation and acceptance from others. Satisfaction of self-esteem needs generates feelings of self-confidence, self-worth and a sense of being useful and necessary in the world.

Dissatisfaction of self-esteem needs in contrast, generate such feelings as inferiority, weakness, passivity and dependency.

### **Self-Actualization**

According to Maslow self-actualization is the person's desire to become everything he is capable of. The person who has achieved this highest level

presses toward the full use of his talents, capacities and potentialities. In short, the self-actualized person is someone who has reached the peak of his potential.

### **Trait and Type Theories of Personality**

Two major themes underlie trait and type theories of personality:

- People possess broad predispositions or traits to respond in certain ways in diverse situations; what this suggests is that people display consistency in their actions, thoughts and emotions across time, events and experiences.
- No two individuals are alike.

### **Gordon Allport's Theory (1937)**

1. Allport's theory asserts that no two individuals are alike. Allport regarded 'traits' as being responsible for these individual differences. According to Allport, trait is a predisposition to act in the same way in a wide range of situations.
2. Allport distinguished between common traits and individual traits. Common traits are shared by several people within a given culture. Individual traits are peculiar to the person and do not permit comparisons among people. They guide, direct and motivate an individual's adjustment. Therefore, they accurately reflect the distinctiveness or uniqueness of his personality.
3. Allport was deeply committed to the study of individual traits. He started calling them as 'personal' dispositions. Common traits were simply called as 'traits'. Allport proposed that there are three types of personal dispositions.
  - *Cardinal disposition:* A cardinal disposition is so dominant that all actions of the person are guided by it. Very few people possess cardinal dispositions. For example: Ms. Nightingale whose actions were driven by compassion for people.
  - *Central disposition:* These are not as dominant as cardinal dispositions, but they influence the person's behavior in a very

prominent way. Therefore they are called the building blocks of personality. For example: A person may have such central dispositions as punctuality, responsibility, attentiveness, honesty, loyalty, etc.

- **Secondary disposition:** These are not very consistent and are thus less relevant in reflecting the personality of the individual. Food and clothing preferences, specific attitudes etc. may be considered as secondary dispositions.

### *Raymond Cattell's Theory (1965)*

- Cattell spoke of the multiple traits that comprise the personality, the extent to which these traits are genetically and environmentally determined and the ways in which genetic and environmental factors interact to influence behavior.
- According to Cattell, personality is that which permits us to predict what a person will do in a given situation. In line with his mathematical analysis of personality, prediction of behavior can be made by means of a specification equation:

$$R = f(S, P)$$

According to this formula the response ( R ) of the person is a function ( f ) of the stimulus ( S ) at a given moment in time, and of the existing personality structure ( P ). This equation conveys Cattell's strong belief that human behavior is determined and can be predicted.

- Traits are a major part of Cattell's theory, which he defined as the individual's stable and predictable characteristics.
- Cattell divided traits into surface traits and source traits. Surface traits are not consistent over time and do not have much value in accounting for the individual's personality. Source traits are the basic building blocks of personality, which determine the consistencies of each person's behavior over an extended period of time.
- Based on extensive research, Cattell identified 16 source traits that constitute the underlying structure of personality (such as outgoing-

reserved; stable-emotional; self-sufficient, group dependent, etc.). He constructed a scale to measure these source traits, which came to be known as '*Sixteen Personality Factor Questionnaire*' (16 PF Questionnaire).

### *Hans Eysenck's Theory*

#### *(Trait-type theory of personality)*

- The essence of Eysenck's theory is that the elements of personality can be arranged hierarchically. In this scheme certain super traits and types such as extroversion exert a powerful influence over behavior.
- Accordingly, Eysenck's focus has been on a small number of personality types, defined by two major dimensions: introversion-extroversion, stability-instability (neuroticism).
- Based on these personality types, Eysenck proposed four separate categories of people:

|           | <b>Stable</b>  | <b>Unstable</b>   |
|-----------|--|---|
| Introvert | <ul style="list-style-type: none"> <li>• Calm</li> <li>• Reliable</li> <li>• Controlled</li> <li>• Peaceful</li> <li>• Careful</li> </ul>        | <ul style="list-style-type: none"> <li>• Moody</li> <li>• Anxious</li> <li>• Rigid</li> <li>• Pessimistic</li> <li>• Reserved</li> </ul>        |
| Extrovert | <ul style="list-style-type: none"> <li>• Leadership</li> <li>• Easygoing</li> <li>• Talkative</li> <li>• Outgoing</li> <li>• Sociable</li> </ul> | <ul style="list-style-type: none"> <li>• Restless</li> <li>• Aggressive</li> <li>• Impulsive</li> <li>• Optimistic</li> <li>• Active</li> </ul> |

- Later on, he added a third type dimension of personality called as psychotism-superego strength. People belonging to this category are selfish, impulsive and opposed to social customs.
- Based on his categorization of personality types, Eysenck constructed an inventory called Personality Questionnaire (EPQ). It covers items from each of the personality types identified by him.
- Throughout his writings, Eysenck consistently emphasized the role of genetic factors and neurophysiological factors, role of the cerebral cortex, autonomous nervous system, limbic

- system, Reticular Activating System (RAS) in explaining individual differences in behavior.
- Because of the use of statistical techniques and the assumption that there is a hierachial organization to basic personality dimensions, Cattell and Eysenck have been called as factor analytic trait theorists.

### **Behavior Theory**

- Behavior theory is based on the premise that all behavior, adaptive and maladaptive is a product of learning.
- Learning is a change in behavior resulting from reinforcement. A related assumption is that, since behavior is learned, it can be unlearned and adaptive behavior can be substituted.
- Behavioral theories attempt to explain how people learn and act.
- Unlike psychodynamic theories, behavioral theories never attempt to explain the cause of mental disorders, but focus on normal human behavior.

### **Stimulus – response theories**

#### **1. CLASSICAL CONDITIONING**

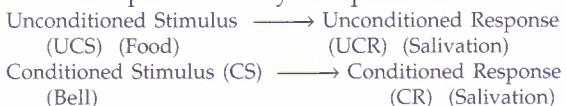
##### **A. Ivan Pavlov**

- The theory of classical conditioning was given by Ivan Pavlov (1849-1936) a Russian physiologist. Pavlov noticed that stomach secretions of dogs were stimulated by other triggers besides food reaching stomach. He found that the sight and smell of food triggered stomach secretions. Thus, a clear connection was made between thought processes and physiologic responses.
- In Pavlov's model, there is Un Conditioned Stimulus (UCS), i.e. food (not dependent on previous training) that elicits an Un Conditional Response (UCR), i.e. salivation (a specific response). Pavlov would then select other stimuli such as a bell, large cue card, etc., presenting this conditioned stimulus just before the food, the unconditioned response.
- If the conditioned stimulus was repeatedly presented before the food, eventually saliva-

tion was elicited only by the conditioned stimulus. This phenomenon was called classical conditioning.

- He demonstrated that a conditioned stimulus could be paired with an unconditioned stimulus to elicit a conditioned response or behavior change. When the unconditioned stimulus was removed, the conditioned stimulus continued to result in the same conditioned response.

This experiment may be represented as :



##### **B. John B.Watson**

- John B. Watson introduced behaviorism, believed that all learning was classical conditioning and that people are born with certain stimulus response connections called reflexes. Examples are sneezing in response to an irritation and the knee-jerk response to a sharp tap on the knee.
- He developed two principles: Frequency and recency. The principle of frequency states that the more frequently a given response is made to a given stimulus, the more likely the response to that stimulus will be repeated. The principle of recency states that the more recently a given response to a particular stimulus is made, the more likely it will be repeated.

#### **2. REINFORCEMENT THEORIES**

##### **A. Edward L.Thorndike**

Thorndike believed in the importance of the effects that followed the response or the reinforcement of the behavior. According to Thorndike, the individual's behavior is shaped through the stamping of the correct responses and stamping out of incorrect responses through trial and error. Thorndike was thus the first reinforcement theorist.

##### **B. B.F.Skinner**

- Basically Skinner revolted against the concept of classical conditioning. He said that man is

an active organism, and not a victim of his environment. He does not wait for the stimulus; instead, he acts or operates on the environment, so as to change it in some way. Thus he called it as operant behavior.

- According to Skinner, operant behavior is determined by the events or consequences that follow the response. If the consequences are favorable, then the organism will repeat the same behavior. In this case, the consequences are said to have provided positive reinforcement and caused repetition of behavior.
- Alternatively, if the consequences are unfavorable, then they reduce the chances of the same behavior from getting repeated. In such a case, the consequences are said to have provided negative reinforcement and reduced the chances of the behavior from recurring again.
- Thus, operant conditioning is called as Type-R conditioning, to emphasize the effect of the response of future behavior. In this way Skinner said that learning is shaped and maintained by its consequences.
- The following is one of the experiments carried out by Skinner to support his concept of operant conditioning:

A hungry rat was placed in a box designed by Skinner which was called as the Skinner box or operant chamber. The chamber contained a lever, which would drop food pellets into the chamber if pressed.

In the beginning the experimenter himself dropped the food pellets into the box, and later stopped. The rat, being hungry, began to explore the box and pressed the lever accidentally. The food pellet was released into the box, and the rat ate it up. After a while, it pressed the lever again, and ate the food pellet which got released. After the third or fourth time, the rat began to press the lever more rapidly. Thus, the food is said to have provided positive reinforcement to the rat, and operant behavior got established, i.e. the rat continued to press the lever, in order to obtain the food pellets.

### Schedules of Reinforcement

Objects or events which provide reinforcement are called as reinforcers. There are two types of reinforcers : Primary and Secondary reinforcers.

*Primary reinforcers* are those which possess inherent reinforcing properties. Examples include food, water, physical comfort, etc. *Secondary or Conditioned reinforcers* are those which acquire their reinforcing qualities through close association with a primary reinforcer. Examples of secondary reinforcers include money, attention, affection and good grades. Skinner put forward the idea of planning of schedules of reinforcement in order to condition the operant behavior of the organism. The important schedules are as follows:

#### 1. Continuous Reinforcement schedule (CR)

This is 100% reinforcement schedule, where every correct response of the individual is rewarded or reinforced. For example, the learner is rewarded for every correct answer he gives to the questions put by his teacher.

#### 2. Fixed-Interval reinforcement schedule (FI)

In this schedule, the individual is rewarded for a response only after a set interval of time. What is important here is the fixed responses during this interval. For example:

- Paying salaries for the work done on a weekly or monthly basis
- Conducting examinations periodically for the students
- Giving a person a periodic allowance, etc.

#### 3. Fixed-Ratio reinforcement schedule (FR)

In this schedule, the individual is reinforced following a 'fixed' number of correct responses. This schedule usually generated extremely high operant levels in the individuals, because the more they respond, the more reinforcement they receive. For example: Paying employees depending on the number of units they produce or sell.

#### 4. Variable-Ratio reinforcement schedule (VR)

In this schedule, reinforcement is intermittent and irregular. The individual does not know when he

is going to be rewarded, and so he remains motivated throughout the learning process. The most common example of this schedule in human behavior is gambling. Here rewards are unpredictable and keep the players motivated, though returns are occasional.

- Even though he was mostly concerned with positive reinforcers, Skinner recognized that negative reinforcers also exist. According to Skinner, negative reinforcers are different from punishment. In negative reinforcement, something negative is taken away or avoided. Positive and negative reinforcement have similar consequences; they both strengthen or reinforce the behavior they follow and increase the changes that the behavior will be repeated. An example of negative reinforcement would be if the child was told by a parent, "if you eat all your salad, you won't have to eat your beans – thereby taking away something unpleasant."
- Punishment can involve adding something negative; punishment can also involve taking away or preventing something positive. Punishment tends to decrease the probability of the response that it follows, making that response less likely in the future. For example: If a patient regularly watches television at 10 pm and the television is removed suddenly because the patient violated a smoking policy, this is punishment.
- Skinner also developed the concept of "shaping" behavior, which has been used in the process of learning how to perform complex tasks.

### 3. COGNITIVE THEORIES

The initial behavioral studies focused attention on human actions without much attention to the internal thinking process. Cognitive theories, an

outgrowth of different theoretical perspectives including the behavioral and the psychodynamic, attempted to link the internal thought processes with human behavior.

#### *Albert Bandura's Social Cognitive Theory*

Acquiring behaviors by learning from other people is the basis of social cognitive theory. Bandura believes that important behaviors are learned by internalizing behaviors of others. According to Bandura learning by observation is achieved through four necessary components: attention, retention, production and motivation.

- Attention occurs when events are selectively noticed.
- Retention is remembering what is learned.
- Production—the actual performance of the behavior.
- Motivation involves the reinforcement for imitating an individual.

An important concept of Bandura's is self-efficacy, a person's ability to deal effectively with the environment. Efficacy beliefs influence how people feel, think, motivate themselves, and behave. The stronger the self-efficacy, the higher the goals people set for themselves and the firmer is their commitment to them. Cognitive processes shape most courses of action, that is, if people believe in positive outcomes. If they have doubts about their efficacy, people view failure scenarios and dwell on things that can go wrong.

### REVIEW QUESTIONS

- Personality development (Nov 2002, Oct 2006)
- What are the factors influencing personality development
- Psychoanalytical theory
- Oedipus complex (Oct 2006)
- Theories of psychosocial development.

# 4

## *Conceptual Models*

- PSYCHOANALYTICAL MODEL
- BEHAVIORAL MODEL
- INTERPERSONAL MODEL
- COMMUNICATION MODEL
- MEDICAL MODEL
- NURSING MODEL
  - Peplau's Theory
  - Orem's Theory
  - Roger's Theory
  - Roy's Theory
- HOLISTIC MODEL

A model is a means of organizing a complex body of knowledge. For example, the linkage between the various concepts related to human behavior may be represented in the form of a model, which can now be referred to as a conceptual model.

The treatment of the mentally ill depends mainly on the philosophy related to mental health and mental illness. The various models or theoretical approaches influencing current practice are:

### **PSYCHOANALYTICAL MODEL**

Psychoanalytical model has been derived from the work of Sigmund Freud and his followers.

Basic assumptions of psychoanalytical model are:

- All human behavior is caused and thus is capable of explanation. Human behavior, however insignificant or obscure, does not occur randomly or by chance. Rather, all human behavior is determined by prior life events.
- All human behavior from birth to old age is driven by an energy called the libido. The goal of the libido is the reduction of tension through the attainment of pleasure. The libido is closely

associated with physiological or instinctual drives (e.g., hunger, thirst, elimination and sex). Release of these drives results in the reduction of tension and experience of pleasure. Hence, the pleasure principle becomes operative when pleasure seeking behaviors are used.

- The personality of the human being can be understood by way of three major hypothetical structures, viz. id, ego and superego. Id represents the most primitive structure of the human personality. It houses the physiological drives. Human behavior originating from the id is impulsive, pleasure-oriented, and disconnected from reality.
- The ego represents that part of the human personality, which is in closest contact with reality. Unlike the id, ego is capable of postponing pleasure until an appropriate time, place or object is available. Unlike the superego, the ego is not driven to blind conformity with rules and regulations. Rather, the ego acting as mediator between the id and superego, gives rise to a much more mature and adaptive behavior.
- The superego is the personality structure containing the values, legal and moral regulations and social expectations that thwart free expression of pleasure-seeking behaviors. The superego thus functions to oppose the id.
- Understandably, humans occasionally experience anxiety when confronted with situations that challenge the tenuous balance between the id and the superego. At these

times, the ego uses defense mechanisms that include repression, denial, regression, rationalization, reaction formation, undoing, projection, displacement, sublimation, isolation, and fixation.

- The human personality functions on three levels of awareness: conscious, preconscious and unconscious. Consciousness refers to the perception, thoughts and feelings existing in a person's immediate awareness. Preconscious content on the other hand, is not immediately accessible to awareness. Unlike conscious and preconscious, content in the unconscious remain inaccessible for the most part.
- The unconscious affects all the three personality structures—id, ego and the superego. Although the id's content resides totally in the unconscious, the superego and the ego have aspects in all the three levels of consciousness. The ego maintains contact with reality, the id and the superego.
- Human personality development unfolds through five innate psychosexual stages—oral, anal, phallic, latent and genital. Although these stages extend throughout the lifespan, the first 6 years of life determine the individual's long-term personality characteristics.

### **Psychoanalytical Process**

Psychoanalysis, described by Freud, makes use of free association and dream analysis to affect reconstruction of personality. Free association refers to the verbalization of thoughts as they occur, without any conscious screening. Analysis of the patient's dreams helps to gain additional insight into his problem and the resistances. Thus dreams symbolically communicate areas of intrapsychic conflict. The therapist then attempts to assist the patient to recognize his intrapsychic conflicts through the use of interpretation.

The patient is an active participant, freely revealing all thoughts exactly as they occur and describing all dreams. By termination of therapy, the patient is able to conduct his life according to an accurate assessment of external reality and is

also able to relate to others uninhibited by neurotic conflicts.

### **Roles of the Patient and the Psychoanalyst**

The patient is to be an active participant, freely revealing all thoughts exactly as they occur and describing all dreams. The psychoanalyst is a shadow person; while the patient is expected to reveal all his thoughts and feelings, the analyst reveals nothing personal.

### **Application to Nursing**

This theoretical perspective has helped mental health professionals to understand psychopathology and stress related behaviors. More importantly, this theory illustrates the importance of not taking human behavior at face value. That is, it helps the psychiatric-mental health nurse to discern and explore the meaning behind human behavior.

### **BEHAVIORAL MODEL**

Prominent theorists of behavioral theory include Ivan Pavlov, John Watson, BF Skinner, etc.

Basic assumptions of behavioral model are:

- All behavior is learnt (adaptive and maladaptive).
- All behavior occurs in response to a stimulus.
- Human beings are passive organisms that can be conditioned or shaped to do anything if correct responses are rewarded or reinforced.
- Maladaptive behavior can be unlearnt and replaced by adaptive behavior if the person receives exposure to specific stimuli and reinforcement for the desired adaptive behavior.
- Deviations from behavioral norms occur when undesirable behavior has been reinforced. This behavior is modified through application of learning theory.

### **Therapeutic Approaches**

- Systematic desensitization
- Token reinforcement
- Shaping

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- Chaining
- Prompting
- Flooding
- Aversion therapy
- Assertiveness and social skills training  
(Refer chapter 14 for details).

### Roles of the Patient and the Behavioral Therapist

The approach is that of a learner and a teacher.

#### *Therapist*

- The therapist is an expert in behavior therapy who helps the patient unlearn his symptoms and replace them with more satisfying behavior.
- The therapist uses the patient's anxiety as a motivational force towards learning.
- The therapist teaches the patient about behavioral approaches and helps him develop behavioral hierarchy.
- The therapist reinforces desired behaviors.

#### *Patient*

- As a learner the patient is an active participant in the therapy process.
- Patient practises behavioral techniques.
- Does homework and reinforcement exercises.

Therapy is considered to be complete when the symptoms subside.

### Application to Nursing

Nurses commonly use behavioral techniques in a wide variety of mental health settings. Additionally, nurses who work with clients having physical disability, chronic pain, chemical dependency and rehabilitation centers also apply these techniques.

### INTERPERSONAL MODEL

Harry S Sullivan is the originator of interpersonal relations theory.

Basic assumptions of interpersonal model are:

- Human being are essentially social beings.

- Human personality is determined in the context of social interactions with other human beings.
- Anxiety plays a central role in the formation of human personality by serving as a primary motivator of human behavior. Especially, anxiety is important in building self-esteem and enabling a person to learn from their life experiences.
- Self-esteem is an important facet of human personality that forms in reaction to the experience of anxiety. Interactions with significant others conveying disapproval or other such negative meanings contribute to self-system formation.
- Security mechanisms are used to reduce or avoid the experience of anxiety. These security mechanisms include sublimation, selective inattention and dissociation.
- Early life experiences with parents, especially the mother, influence an individual's development throughout life.
- Human development proceeds through six stages of development: infancy, childhood, juvenility, pre-adolescence, early adolescence and late adolescence. According to interpersonal theory, juvenile and preadolescent stages hold the greatest potential for correction of previous behavior and personality difficulties.

### Interpersonal Therapeutic Process

The interpersonal therapist, like the psychoanalyst, explores the patient's life history. Components of self-esteem are identified, including the security operations that are used to defend the self.

The process of therapy is essentially a process of re-education as the therapist helps the patient identify interpersonal problems and then encourages him to try out more successful styles of relating.

Therapy is terminated when the patient has developed the ability to establish satisfying human relationships thereby meeting his basic needs.

## Roles of the Patient and the Interpersonal Therapist

Sullivan describes the therapist as a participant observer, who should not remain detached from the therapeutic situation. The therapist's role is to actively engage the patient to establish trust and to empathize. He will create an atmosphere of uncritical acceptance to encourage the patient to speak openly.

The patient's role is to share his concerns with the therapist and participate in the relationship to the best of his ability.

The relationship itself is meant to serve as a model of interpersonal relationships. As the patient matures in his ability to relate, he can then improve and broaden his other life experiences with people outside the therapeutic situation.

## Application to Nursing

Sullivan's interpersonal theory has been the cornerstone of psychiatric-mental health nursing curricula in the undergraduate and graduate levels.

Nurse-client one-to-one interaction or interpersonal process is based on Sullivan's interpersonal theory. The use of interpersonal process recordings in the clinical aspect of psychiatric-mental health nursing courses is also derived from Sullivan's interpersonal theory.

## COMMUNICATION MODEL

Communication refers to the reciprocal exchange of information, ideas, beliefs, and feelings among a group of persons. The theorists who particularly emphasized the importance of communication are Eric Berne (founder of transactional analysis), Paul Watzlawick and his associates.

Basic assumptions of communication model are:

- The understanding of the meaning of behavior is based on the clarity of communication between the sender and receiver.
- Breakdown in successful transmission of information causes anxiety and frustration.

- All behavior is communication, whether verbal or non-verbal.
- Disruptions in behavior may then be viewed as a disturbance in the communication process, and as an attempt to communicate.

## Communication Therapeutic Process

Therapists locate the disruptions within the communication process and also the interventions made in the patterns of communication.

This may take place in individuals, groups or families. The communication pattern is first assessed and the disruption diagnosed. The patient is then helped to recognize his own disrupted communication.

## Roles of Patient and Therapist

### *Therapist*

- The communication therapist induces changes in the patient by intervening in the communication process. Feedback is given about the person's success at communicating.
- The therapist demonstrates how to relate to others clearly.
- Non-verbal communication is also emphasized, particularly in terms of congruence with verbal behavior.
- The therapist teaches principles of good communication.

### *Patient*

- The patient must be willing to become involved in an analysis of his style of communicating.
- The responsibility for changing rests with the patient. Significant others often are included in communication therapy to bring change in the patient.

## Application to Nursing

This theory helps mental health nurses to understand communication process and to correct communication disturbances.

### MEDICAL MODEL

The medical model dominates much of modern psychiatric care. Other health professionals may be involved in interagency referrals, family assessment and health teaching, but physicians are viewed as the leaders of the team when this model is in effect. A positive contribution of the medical model has been the continuous exploration for causes of mental illness using the scientific process.

Basic assumptions of medical model are:

- Medical model believes that deviant behavior is a manifestation of a disorder of the central nervous system.
- It suspects that psychiatric disorders involve an abnormality in the transmission of neural impulses, difficulty at the synaptic level, and neurochemicals such as dopamine, serotonin and norepinephrine.
- It focuses on the diagnosis of a mental illness and subsequent treatment based on this diagnosis.
- Environmental and social factors are also considered in the medical model. They may be either predisposing or precipitating factors in an episode of illness.
- Another branch of research focuses on stressors and the human response to stress. These researchers suspect that humans have a physiological stress threshold that may be genetically determined.

### Medical Therapeutic Process

The physician's examination of the patient includes history of the present illness, past history, social history, medical history and review of systems, physical examination and mental status examination. Additional data may be collected from significant others, and past medical records are reviewed if available. A preliminary diagnosis is then formulated pending further diagnostic studies and observation of the patient's behavior. After the diagnosis is made treatment is instituted.

Somatic treatments including pharmacotherapy, electroconvulsive therapy and occasionally

psychosurgery, are important components of the treatment process.

### Roles of the Patient and the Medical Therapist

- The physician as the healer identifies the patient's illness and institutes a treatment plan.
- Physician admits the patient in a psychiatric institution.
- The role of the patient involves admitting that he is ill.
- Patient practices prescribed therapy regimen and reports the effects of therapy to the physician.

### Application to Nursing

Psychiatric-mental health nurse uses this model for assessment, diagnosis, planning and implementing nursing care to the patient.

This model helps psychiatric-mental health nurses to understand the physiological changes occurring due to psychiatric disorders.

### NURSING MODEL

Nursing focuses on the individual's response to potential or actual health problems. Under the nursing model, human behavior is viewed from a holistic perspective.

#### *Nursing View of Behavioral Deviations*

- Behavior is viewed on a continuum from healthy adaptive responses to maladaptive responses that indicate illness.
- Each individual is predisposed to respond to life events in unique ways. These predispositions are biological, psychological, sociocultural, and the sum of the person's heritage and past experiences.
- Behavior is the result of combining the predisposing factors with precipitating stressors. Stressors are life events that the individual perceives as challenging, threatening or demanding. The nature of the behavioral response depends on the person's primary appraisal of the stressor and his secondary appraisal of the coping resources available to him.

- A stressor that has primary impact on physiological functioning also affects the person's psychological and sociocultural behavior. For instance, a man who had a myocardial infarction may also become severely depressed, because he fears he will lose his ability to work. On the other hand, the patient who enters the psychiatric inpatient unit with major depression may be suffering from malnutrition and dehydration because of his refusal to eat or drink. The holistic nature of nursing encompasses all of these facets of behavior and incorporates them into patient care planning.

### Nursing Process

Nursing intervention may take place at any point on the continuum. Nursing diagnosis may focus on behavior associated with a medical diagnosis or other health behavior that the patient wishes to change.

A nurse may practice primary prevention by intervening in a potential health problem, secondary prevention by intervening in an actual acute health problem or tertiary prevention by intervening to limit the disability caused by actual chronic health problems. The nursing assessment of the patient includes presenting complaints, past history, family history, personal history, occupational history, sexual history, physical examination and mental status examination. Additional data may be collected from significant others and by reviewing the systems. A nursing diagnosis is then formulated and based on this diagnosis, planning and interventions are carried out. Finally, evaluation will be done to find out the effectiveness of nursing interventions.

Providing nursing care is a collaborative effort, with both the nurse and the patient contributing ideas and energy to the therapeutic process.

### SUMMARY OF SELECTED NURSING THEORIES

#### Peplau's Theory

Peplau proposed an interpersonal theory applicable to nursing practice in general, and to

psychiatric-mental health nursing in particular. It focuses primarily on the nurse-client relationship. Peplau's theory describes, explains, predicts and to some extent, permits control of the sequence of events occurring in the nurse-client relationship.

Peplau describes the interpersonal aspects of nursing as a process consisting of four phases. These are orientation, identification, exploitation and resolution phases.

While working with the client through these phases, the nurse assumes six roles: resource person, technical expert, teacher, leader, surrogate parent and a counselor.

Peplau's theory continues to apply to today's nursing scene, especially with respect to long-term psychiatric care in outpatient and home health settings.

#### Orem's Theory

Dorothea E. Orem's theory is based on the premise that people need a composite of self-care actions to survive. Self-care actions consist of all behaviors performed by people to maintain life and health. The capacity of the client and the client's family to perform self-care is called self-care agency. Orem states that a need for nursing care exists if the client's self-care demand exceeds the client's self-care agency. Thus the goal of nursing is to meet the client's self-care demands until the client and his family are able to do so.

Orem's theory describes three types of self-care:

- Universal self-care behaviors, required to meet physiological and psychosocial needs.
- Developmental self-care behaviors, required to undergo normal human development.
- Health deviation self-care behaviors, required to meet client's needs during health deviations.

The classification of self-care behaviors in this manner helps to ensure complete assessment of the client's self-care agency.

Assessment focuses on the client's self-care demand, self-care agency and self-care deficits. A plan is formulated from the information obtained

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in the assessment, that indicates the nursing approach needed to meet the client's needs, which can be categorized as follows:

- Wholly compensatory, in which the client does not participate behaviorally in self-care.
- Partially compensatory, in which the client and nurse participate behaviorally in meeting the client's self-care needs.
- Educative-developmental, in which the client meets self-care needs with minimal nursing assistance.

To implement the required nursing approach, the nurse uses one of five behaviors: acting or doing for the client, guiding, supporting, providing and teaching.

### Roger's Theory

Roger's model focuses on the individual as a unified whole in constant interaction with the environment. The unitary person is viewed as an energy field that is more than as well as different from the sum of the biological, physical, social and psychological parts. In Roger's model, nursing is concerned with the unitary person as a synergistic phenomenon.

Nursing science is devoted to the study of nature and direction of unitary human development. Nursing practice helps individuals achieve maximum well-being within their potential.

### Roy's Theory

According to Callista Roy's theory, the goal of nursing is to promote the client's adaptation in health and illness. This goal is achieved through the nurse's efforts to change, manipulate or block stress-producing stimuli that may impinge on the client. The theory assumes that this kind of nursing intervention assists the client to cope more effectively through reducing stress.

Roy's theory assumes that all human beings are having adaptive systems, and change in response to stimuli. If the change is viewed as a positive one that promotes the person's integrity then the change can be considered adaptive. If the change does not promote the person's integrity then the change can be considered maladaptive.

The nursing process used in Roy's theory involves two levels of assessment. The first level includes observation of behavior related to the four adaptive modes: physiologic, self-concept, role function and interdependence. These four modes represent methods used by the client to adapt. The second level of assessment consists of identifying focal, contextual and residual stimuli. The focal stimulus represents the immediate dominant stimulus affecting the client, such as injury, stress or illness. Contextual stimuli include the environment, the client's family and all other background factors related to the focal stimulus. Residual stimuli consist of the client's previous background, beliefs, attitudes and traits.

According to Roy's theory, a person's adaptation level is a function of focal, contextual and residual stimuli. When a person encounters stresses from these stimuli that surpass innate and acquired mechanisms to cope effectively, the person behaves ineffectively as demonstrated by one or more of the adaptive modes. At this point, nursing intervention is required. This emphasizes on the client's behavior, stimuli determining the client's behavior, and the nurse intervening in some way to interfere with the stimuli.

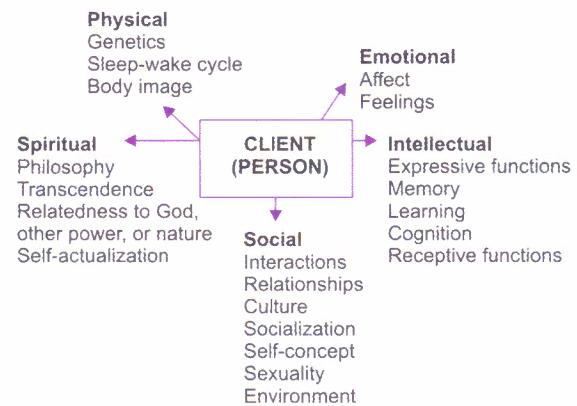
### HOLISTIC MODEL

The holistic view of the patient, with the body and soul seen as inseparable, and the patient viewed as a member of a family and community, was central to Nightingale's view of nursing. The primary goal of nursing is to help clients develop strategies to achieve harmony within themselves and with others, nature and the world. Integrative functioning of the client's physical, emotional, intellectual, social and spiritual dimensions is emphasized. Each person is considered as a whole, with many factors contributing to health and illness.

### Major Concepts

Five major concepts are generally accepted as premises of holistic health care philosophy:

- First, each person is multidimensional; one's physical, emotional, intellectual, social and spiritual dimensions are in constant interaction with each other:
    - the physical dimension involves everything associated with one's body, both internal and external
    - the emotional dimension consists of affective states and feelings, including motor behavior associated with emotion, the experienced aspect of emotion, and the physiological mechanisms that underlie emotion
    - the intellectual dimension includes receptive functions; memory and learning, cognition and expressive functions
    - the social dimension is based on social interaction and relationships, more so the global concept of culture
    - the spiritual dimension is that aspect of a person from which meaning in life is determined through which transcendence over the ordinary is possible
  - The second premise of holistic care philosophy is that the environment makes significant contributions to the nature of one's existence. Each person's environment consists of many factors that are influential in that person's quality of life. Consequently, people cannot be fully understood without consideration of environmental factors such as family relationships, culture, and physical surroundings. Individuals interact with their unique environments through all dimensions, based on subjective experience as well as external stimuli.
  - The third premise is that each person experiences development across his life cycle; in each stage of life, the individual experiences and confronts different issues or similar issues in different ways. One's experience of each stage of life, forms the basis for further development as one moves through the life cycle.
  - Fourth, the holistic health care model maintains that stress is a primary factor in health and illness. Any event or circumstance can act as a stressor. Regardless of the source, stress has an impact on the whole person. Examples of stressors directly affecting the physical dimension include stressors associated with genetic factors, physiological processes, and body image. Emotional stress may result from any experience or situation. Examples include poor physical conditions, perceived social inequities, a significant loss, intellectual incompetence, and a sense of meaninglessness. Stressors affecting the intellectual dimension may include factors that interfere with receptive functions, memory and learning, cognitive functions, and expressive functions. Social stressors may arise from interactions and relationships with other people, as well as from more general societal and cultural factors. Stressors affecting the spiritual dimension may be any factors that interfere with one's ability to meet spiritual needs.
  - Fifth, people are ultimately responsible for the directions their lives take and the lifestyles they choose. Within a holistic framework, people are viewed as active participants in and contributors to their health status; they are willing to learn from illness and strive towards healthier choices.
- The following is a diagrammatic representation of the client viewed from a holistic perspective:



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Recognizing all human dimensions encourages a balanced and whole view of a person. Each facet of an individual is important and contributes to the quality of life experience. All dimensions are intricately interwoven, and the person as a whole functioning organism is more than the simple combination of dimensions. The holistic model emphasizes that all the dimensions of the individual should be considered when planning and instituting care.

### **REVIEW QUESTIONS**

- Psychoanalytical model (Feb 2000, Oct 2004)
- Dream analysis
- Behavioral model
- Interpersonal model
- Self care model (Oct 2004)
- Nursing model
- Holistic model (Apr 2002)

# 5

## Nursing Process in Psychiatric Nursing

- HISTORICAL OVERVIEW OF NURSING PROCESS IN PSYCHIATRIC NURSING
- NURSING PROCESS
  - Definition
  - Nursing Assessment
  - Nursing Diagnosis
  - Planning
  - Implementation
  - Evaluation
- METHODS OF ASSESSMENT IN PSYCHIATRY
  - History Taking
  - Mental Status Examination
  - Physical Investigations for Psychiatric Patients
  - Psychological Assessment in Psychiatric Nursing
- CHILD AND ADOLESCENT PSYCHIATRY ASSESSMENT FORMAT
- HISTORY COLLECTION IN ALCOHOL DEPENDENCE
- GERIATRIC HISTORY COLLECTION FORMAT

Contd...

|        |   |
|--------|---|
| 1960s  | Orlando was among the first to describe nursing as deliberative process with a focus on the interpersonal relationship.                       |
| 1970s  | Psychiatric nursing texts included the nursing process as a method for organizing nursing care within a conceptual framework.                 |
| 1980s  | Mental health-psychiatric nurses continue to refine their use of the nursing process.   |
| 1990s  | With increased understanding, the mental health-psychiatric nurse more deliberately applies the nursing process.                              |
| Future | Psychiatric nurses will engage in more research to systematically examine the effect of the nursing process on the nurse-client relationship. |

### HISTORICAL OVERVIEW OF NURSING PROCESS IN PSYCHIATRIC NURSING

| Dates               | Events  |
|---------------------|---|
| Before World War II | Mental health-psychiatric nurses depended mainly on experience, rote procedure, and intuitive judgment as a basis for nursing care.   |
| 1940s               | Mental health-psychiatric nurses had some awareness of theory but still provided primarily custodial care with no attention to systemic approach to nursing care.   |
| 1950s               | Psychiatric nurses were using nursing care plans as a tool for communicating their practice. Peplau developed a model of nursing care that emphasized a systemic approach to the nurse-client relationship. |

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### NURSING PROCESS

#### Definition

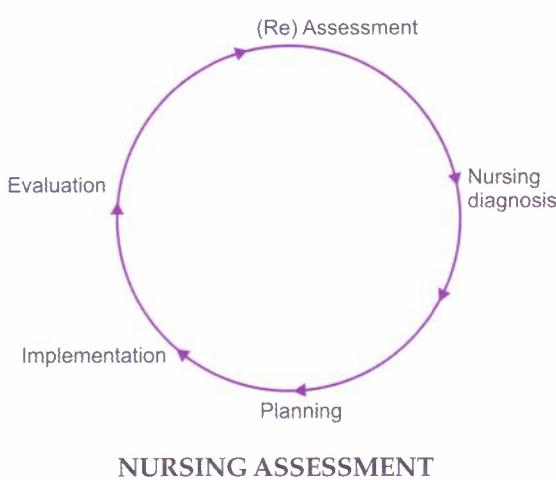
Nursing process is an orderly, systematic manner of determining the client's problems, making plans to solve them, initiating the plan or assigning others to implement it and evaluating the extent to which the plan was effective in resolving the problems identified.

—Yura and Walsh, 1978

The nursing process provides a scientific framework for the delivery of professional nursing care.

Nursing process consists of **five** steps:

1. Assessment
2. Nursing diagnosis or Analysis
3. Nursing goal or Planning or Objectives
4. Implementation or Intervention
5. Evaluation



In this step information is gathered to establish a database for best possible care of the patient.

The nursing assessment is deliberate and systematic collection of bio-psychosocial information or data is done to determine current and past health and functional status and to evaluate past and present coping patterns.

### **Techniques of Data Collection in Psychiatric Nursing**

1. Patient observation
2. Patient interview (Process recording)
3. Family interview
4. Physical examination
5. Mental status examination
6. Records and diagnostic reports
7. Collaboration with colleagues.

### **BIOPSYCHOSOCIAL ASSESSMENT IN PSYCHIATRIC NURSING**

#### **I. Biologic Dimension**

- Present history
- Past psychiatric and medical history
- Personal history
  - Perinatal history
  - Childhood history
  - Educational history
  - Play history
  - Obstetrical history

- Sexual and marital history

- Physical examination
  - Body system review
  - Neurological status
  - Laboratory results
- Physical functions
  - Activity / Exercise
  - Sleep
  - Appetite and nutrition
  - Hydration
  - Sexuality
  - Self care
- Pharmacological assessment

#### **II. Psychological Dimension**

- General appearance and behavior
  - Psychomotor activity
  - Attitude
- Speech
- Mood
  - Affect and emotions
- Thought
- Perception
- Cognitive functions
- Insight
- Judgment
- Abstract reasoning and comprehension
- Memory
- Behavioral responses
- Self concept
  - Body image
  - Self esteem
  - Personal identity
- Present and past coping patterns
- Risk assessment
  - Suicidal ideation
  - Assault or homicidal ideation

#### **III. Social Dimension**

- Functional status
- Social systems
  - Cultural assessment
  - Family assessment
  - Community support and resources
- Spiritual assessment
- Occupational status
- Economic status
- Legal status
- Quality of life

## NURSING DIAGNOSIS

Nursing diagnoses are defined as clinical judgments about individual, family or community responses to actual and potential health problems. Nursing diagnoses are used to describe an individual patient's condition, to prescribe nursing interventions, and to delineate the parameters for developing outcome criteria.

The basic level psychiatric nurse identifies nursing problems by using the nomenclature specified by the North American Nursing Diagnoses Association (NANDA).

A nursing diagnosis describes an existing or high-risk problem and requires a three-part statement.

1. The health problem (Problem, 'P')
2. The etiological or contributing factors (Etiology, 'E')
3. The defining characteristics (Signs and symptoms, 'S').

For example:

- High risk for self directed violence related to depressed mood, feeling of worthlessness, anger turned inward on the self.
- Powerlessness related to dysfunctional grieving process, lifestyle of helplessness, evidenced by feelings of lack of control over life situations, over dependence on others to fulfill needs.

## PLANNING

The planning phase consists of the total planning of the patient's overall treatment to achieve quality outcomes in a safe, effective, and timely manner. Nursing interventions with rationales are selected in the planning phase based on the client's identified risk factors and defining characteristics. The process of planning includes:

- Collaboration by the nurse with patients, significant others, and treatment team members
- Identification of priorities of care
- Critical decisions regarding the use of psychotherapeutic principles and practices (Identify the most appropriate nursing intervention)

- Coordination and delegation of responsibilities.

In this nurse will choose nursing interventions appropriate to an individual's identified problem with specific expected outcomes.

Once the nursing diagnoses are identified, the next step is the prioritization of the problems in order of importance. Highest priority is given to those problems that are life threatening. Next in the priority are those problems that are likely to cause destructive changes. Lowest in priority are those issues that are related to normative or developmental experiences. Psychiatric nurses often use Maslow's hierarchy of needs to prioritize nursing diagnoses.

## Outcome Identification

Outcomes can be defined as a patient's response to the care received. Outcomes are the end result of the process. Measuring outcomes not only demonstrates clinical effectiveness but also helps to promote rational clinical decision-making on the part of the nurse.

Outcome identification should be:

- Patient centered
- Singular
- Observable
- Measurable
- Time limited
- Mutual
- Realistic

| Diagnosis   | Outcome                                     | Intervention   |
|---|---|--|
| Impaired social interaction (Isolates self from others) | Patient will attend group sessions everyday | Using a contract format explain the role and responsibility of patients. |

## Correct and Incorrect Outcome Statements

| Nursing diagnosis  | Correct outcome   | Incorrect outcome                                       |
|--------------------|---|---|
| Anxiety            | Verbalizes feeling calm, relaxed, with absence of muscle tension and diaphoresis; practices deep breathing. | Exhibits decreased anxiety, engages in stress reduction |
| Ineffective coping | Makes own decisions to attend groups; seeks staff for interaction.  | Demonstrates effective coping abilities                 |

### IMPLEMENTATION

In the implementation phase nurse sets interventions prescribed in the planning phase.

Nursing interventions (also known as nursing orders or nursing prescriptions) are the most powerful pieces of the nursing process. Interventions are selected to achieve patient outcome and to prevent or reduce problems. Implementation serves as a blueprint of plan.

Nursing interventions are classified as independent, interdependent and dependent.

### Nursing Intervention in Psychiatric Nursing

#### *Interventions for biological dimension*

- Self care activities
- Activity and exercise
- Nutritional interventions
- Relaxation interventions
- Hydration interventions
- Thermoregulation intervention
- Pain management
- Medication management

#### *Interventions for psychological dimension*

- Counseling interventions
- Conflict resolutions
- Bibliotherapy
- Reminiscence therapy
- Behavior therapy
- Cognitive therapy
- Psycho-education
- Spiritual interventions

#### *Intervention for social dimensions*

- Group interventions
- Family intervention
- Milieu therapy

### EVALUATION

Evaluation is the process of determining the value of an intervention. Nurses determine the effectiveness of interventions with particular patients. Nurses evaluate selected interventions by judging the patients progress towards the outcome set down in the nursing care plan.

### Conclusion

Psychiatric treatment is a team effort; basic outcomes often reflect the combined effects of the interventions of nurses, physician, occupational therapist, psychologists and social workers.

### METHODS OF ASSESSMENT IN PSYCHIATRY

- History Taking
- Mental Status Examination
- Physical Investigations
- Psychological Assessment

### History Taking in Psychiatric Nursing

#### I. Identification data

|                 |            |        |
|-----------------|------------|--------|
| Name            | Age        | Sex    |
| Father / Spouse |            |        |
| Address         |            |        |
| Education       | Occupation | Income |
| Marital status  | Religion   |        |

#### II. Informant

#### III. Presenting chief complaint (with duration in chronological order)

#### IV. History of present illness

Duration (weeks/months/years):  
Mode of onset: abrupt/acute/subacute/insidious (<48 hrs)/ <1 wk / (1-2 wks)  
Course: continuous/episodic/fluctuating/deteriorating/improving/unclear

##### Precipitating factors:

Description of present illness (chronological description of abnormal behavior, associated problems like suicide, homicide, disruptive behavior; thought content, speech, mood states, abnormal perception, biological functioning, social functioning, occupational functioning, changes in ADLs)

#### V. Treatment history

Drugs (name of the drug, dose, route, side-effects, if any)  
ECT  
Psychotherapy  
Family therapy  
Rehabilitation

#### VI. Past psychiatric and medical history

Hospitalization (psychiatric):  
Substance use:  
Surgical procedures/accidents/ head injury/convulsions/unconsciousness/DM/HTN/CAD/venereal disease/HIV positivity/any other

### VII. Family history

*Genogram (family of origin)*

Description (describe each family member briefly: age, education, occupation, health status, relationship with the patient, age at death, mode of death)

### VIII. Personal history

#### (A) Perinatal history

Antenatal period: uneventful/eventful (specify)  
 Birth : full-term / premature / postmature  
 Delivery : normal / instrumental / cesarean  
 Birth cry : immediate/delayed  
 Birth defects:  
 Postnatal complications: cyanosis/convulsions jaundice  
 Any other :

#### (B) Childhood history

Primary caregiver:  
 Feeding: breastfed/artificial  
 Age at weaning:  
 Developmental milestones: normal/delayed  
 Behavior and emotional problems: thumb sucking/temper tantrums/stuttering  
 head-banging/body rocking/nail biting  
 enuresis/morbid fears/night terrors  
 somnambulism

#### (C) Educational history

Age at beginning of formal education:  
 Academic performance:  
 Academic and extracurricular achievements, if any:  
 Relationships with peers and teachers:  
 School phobia : yes/no Truancy: yes/no  
 Reason for termination of studies:

#### (D) Play history

Games played (at what stage and with whom):  
 Relationships with playmates:

#### (E) Emotional problems during adolescence

Running away from home/delinquency/smoking/drug-taking/any other (specify)

#### (F) Puberty

Age at appearance of secondary sexual characteristics:  
 Anxiety R/T puberty changes:  
 Age at menarche:  
 Reaction to menarche:  
 Regularity of cycles, duration of flow:  
 Abnormalities, if any (menorrhagia, dysmenorrhea, etc):

#### (G) Obstetrical history

LMP:  
 Number of children:  
 Any abnormalities associated with pregnancy, delivery, puerperium:  
 Termination of pregnancy, if any  
 Menopause (including any associated problems):

#### (H) Occupational history

Age at starting work:  
 Jobs held in chronological order:  
 Reasons for changes:  
 Current job satisfaction:  
 (including relationships with authorities, colleagues, subordinates)  
 Whether job is appropriate to client's background:

#### (I) Sexual and marital history

*Genogram (family of procreation):*  
 Type of marriage: self-choice/arranged  
 Duration of marriage:  
 Interpersonal and sexual relations: satisfactory/unsatisfactory  
 Details of spouse and children:

#### (J) Premorbid personality

- (a) Interpersonal relationships:  
 Extrovert/introvert  
 Family and social relationships
- (b) Use of leisure time:
- (c) Predominant mood:  
 Optimistic/pessimistic; stable/fluctuating;  
 cheerful/despondent  
 Usual reaction to stressful events
- (d) Attitude to self and others:  
 Self-appraisal of abilities, achievements and failures  
 General attitudes towards others
- (e) Attitude to work and responsibility:
- (f) Religious beliefs and moral attitudes:
- (g) Fantasy life:  
 Daydreams → frequency and content.
- (h) Habits:  
 Eating pattern : regular/irregular  
 Elimination : regular/irregular  
 Sleep : regular/irregular  
 Use of drugs, tobacco, alcohol:

### Mental Status Examination

#### [A] General Appearance and Behavior

*Appearance:* looking one's age/older/younger

*Level of grooming:* normal/shabbily dressed/over-dressed/idiosyncratically dressed

*Level of cleanliness:* adequate/inadequate/overtly clean

*Level of consciousness:* fully conscious and alert/drowsy/stuporous/comatosed

*Mode of entry:* came willingly/persuaded/brought using physical force

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*Cooperativeness:* normal/more than so/less than so

*Eye-to-eye contact:* maintained/difficult/not maintained

*Psychomotor activity:* normal/increased/decreased

*Rapport:* spontaneous/difficult/not established

*Gesturing:* normal/exaggerated/odd

*Posturing:* normal posture/catatonic posture

*Other movements:* stereotypes/tremors/EPS/AIMs (abnormal involuntary movements)

*Other catatonic phenomena:* automatic obedience/negativism/excessive cooperation/waxy flexibility/echopraxia/echolalia

*Conversion and dissociative signs:*

*Compulsive acts or rituals:*

*Hallucinatory behavior:*

(Smiling and talking to self, odd gesturing)

### [B] Speech

*Initiation:* spontaneous-speaks when spoken to/minimal/mute

*Reaction time:* normal/delayed/shortened/difficult to assess

*Rate:* normal/slow/rapid

*Productivity:* monosyllabic/elaborate replies/pressured

*Volume:* normal/increased/decreased

*Tone:* normal variation/monotonous

*Relevance:* fully relevant/sometimes off target/irrelevant

*Stream:* normal/circumstantial/tangential

*Coherence:* fully coherent/loosening of associations

*Others:* rhyming/punning/echolalia perseveration/neologism

Sample of speech (in response to open-ended questions):

### [C] Mood

*Subjective:*

*Objective:*

(Predominant mood state/appropriate/inappropriate/irritable/labile/blunted/lattened)

### [D] Thought

*Stream:* normal/racy thoughts (pressure of thought)/retarded thinking (poverty of thought)/thought block/muddled or unclear thinking/flight of ideas

*Form:* normal/formal thought disorder (specify with a sample of speech)

*Content:* (a) Ideas/delusions of:

worthlessness/helplessness/hopelessness/guilt/hypochondriacal/poverty/nihilistic/death wishes/suicidal/grandiose/reference/control/persecution/bizarre

(b) Thought alienation phenomena:  
thought insertion/thought withdrawal/thought broadcasting

(c) Obsessional/compulsive phenomena:  
thoughts/images/ruminations/doubts/impulsive rituals

### [E] Perception

*Hallucinations:* Auditory

Visual

Olfactory

Gustatory

Tactile

*Somatic passivity:*

*Déjà vu / jamais vu:*

### [F] Cognitive Function (neuropsychiatric assessment)

*Consciousness*

conscious/cloudy/comatosed

*Orientation*

Time: appropriate time/day/night/date/month/year

Place: kind of place/area/city

Person: self/close associates/hospital staff

### Attention

normally aroused/aroused with difficulty

digit forward

digit backward

### Concentration

normally sustained/sustained with difficulty/  
distractible

100-7

40-3

20-1

Name of months (backwards)

Name of weekdays (backwards)

### Memory

- (a) Immediate (same test as for attention):
- (b) Recent: (recent happenings - last meal, visitors etc)
  - verbal recall - 3 unrelated objects
    - 5 unrelated objects, or imaginary address of 5 items
- (c) Remote:
  - personal events:
  - impersonal events:
  - illness-related events:

### Intelligence

General fund of information:

Arithmetic ability: mental arithmetic /written sums

### Abstraction

Normal/concrete

Interpretation of proverbs:

Similarities between paired objects:

Dissimilarities between paired objects:

### [G] Insight

Awareness of abnormal behavior/experience:  
yes / maybe / no

Attribution to physical causes: yes / maybe / no

Recognition of personal responsibility: yes /  
maybe / no

Willingness to take treatment: yes / maybe / no

### [H] Judgment

Personal: intact / impaired

Social: intact / impaired

Test: intact / impaired

### Diagnostic formulation

#### Physical Investigations for Psychiatric Patients

- (A) Routine: general screening
  - e.g. hemogram, urinalysis
  - (Additional investigations may be ordered in special populations)
- (B) Routine: specific
  - Based on diagnosis-e.g. liver function tests in alcoholics
  - Based on treatment-e.g. pre-lithium, pre-ECT work-up investigations
  - Based on ongoing management-e.g. blood counts in patients on clozapine treatment
- (C) Non-routine:
  - Based on need and index of suspicion
    - e.g. thyroid function tests in suspected hypothyroidism during lithium therapy; pregnancy tests in amenorrhea during treatment with potential teratogens.
- (D) Common neuropsychiatry investigations
  - Electroencephalogram (EEG)
  - Computed tomographic (CT) scanning
  - Magnetic resonance imaging
  - The sleep EEG (polysomnogram)

### Psychological Assessment in Psychiatric Nursing

Psychological testing of patients is ideally conducted by a clinical psychologist who has been trained in the administration, scoring and interpretation of these procedures.

1. To assist in diagnosis:
  - E.g. Rorschach inkblot test
2. To assist in the formulation of psychopathology and in the identification of areas of stress and conflict:
  - E.g. Thematic apperception test
3. To determine the nature of the deficits that are present:

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- Cognitive neuropsychological assessments
- 4. To assess severity of psychopathology and response to treatment:
  - Hamilton rating scale for depression
  - Brief psychiatric rating scale
- 5. To assess general characteristics of the individual:
  - Assessment of intelligence
  - Assessment of personality

### CHILD AND ADOLESCENT PSYCHIATRY ASSESSMENT FORMAT

- A. Demographic Data
  - Name: Address:
  - Age: Sex:
  - Income: Urban / Semi-Urban / Rural
  - Hospital No.:
  - Informant: Mother / Father / Others
- B. Chief complaints (with duration in brief):
- C. History of present illness:
- D. Family History:
  - 1. Nuclear      1. Consanguinous      1. Mental illness
  - 2. Non-nuclear    2. Non-consanguinous    2. Epilepsy
  - 3. Mentally retarded
  - 4. Others
- E. Personal History:
  - Antenatal history
  - Perinatal history
  - Postnatal history
  - Milestones
  - Current schooling : Yes / No
  - Habits, interest and talents, sexual history
- F. Past history:
  - 1. Psychiatric
  - 2. Neurotic
  - 3. Others
- G. Current functioning
  - 1. Intelligence
    - a. Average b. Below c. Above d. Not known
  - 2. School Performance
    - a. Average b. Below c. Not appropriate d. Not known
  - 3. Self-Help: Age appropriate
    - a. Toilet - Yes / No
    - b. Dressing - Yes / No
    - c. Eating - Yes / No
    - d. Bathing / Washing - Yes / No
- H. Physical examination -
  - Vision
  - Hearing
  - CNS
  - Chest
- I. Treatment history till date

- J. Mental Status Examination
  - Attention & concentration
  - Activity level
  - Motor behavior
  - Speech and language ability
  - General intelligence
  - Mood and affect
  - Thought processes
  - Perception
- K. Summary

### HISTORY COLLECTION IN ALCOHOL DEPENDENCE

- A. Demographic Data
  - Name: Age: Sex:
  - Occupation: Income:
  - Marital status - Married / Single / Widow
  - L.P.No. : Address:
  - Education :
  - Informant :
- B. Chief complaints (in chronological order with duration)
- C. History of present illness
  - 1. First drink causes
  - 2. First experience with alcohol
  - 3. The type and volume of first drink - Hard drink/ Regular drink
  - 4. History of tolerance
  - 5. History of craving
  - 6. History of loss of control
  - 7. History withdrawal features - when abstinent from alcohol
  - 8. History of blackouts
  - 9. History of salience
    - (Restricting all the activities and concentrating only on alcohol seeking behavior, not even going to work)
  - 10. What are the reasons for excessive consumption of alcohol
  - 11. Maintaining factors/reasons
  - 12. Previous history of abstinence
  - 13. Money spent for alcohol
  - 14. Medical problems associated with alcoholism
  - 15. Psychiatric problems associated with alcoholism
    - Cognitive deficits
    - History of dementia
  - 16. Co-morbidity
  - 17. History of any other substance abuse
- D. Family history
  - Family history of similar problems
  - Interpersonal relationship in the family
  - Family history of psychiatric disorders
    - Psychosis
    - Mood disorders
    - Neurotic disorders
    - Substance abuse
    - Epilepsy

Genogram

- E. Personal history
- F. Marital history
  - Role reversal
  - Emotional disorders in children
  - History of exposure to extra marital relationship
  - Sexual dysfunction
- G. Premorbid personality
  - Dependence
  - Anankastic
  - Passive aggressive
  - Anti-social

### **GERIATRIC HISTORY COLLECTION FORMAT**

- I. Demographic Data
 

|                                      |          |      |
|--------------------------------------|----------|------|
| Name:                                | Age:     | Sex: |
| Occupation:                          | Income:  |      |
| Marital Status: Married/Single/Widow |          |      |
| I.P. No.:                            | Address: |      |
| Education                            |          |      |
| Informant:                           |          |      |
- II. Chief Complaints
- III. Precipitating Factors
  - Head injury
  - Infection
  - Sensory handicaps
  - Retirement
  - Bereavement
  - Any other
- IV. History of Present Illness
  - Stress
  - Qualitative or quantitative changes in routine activities
  - Cognitive function
  - Habits and others
- V. Past Medical History
- VI. Past Psychiatric History
- VII. Mental Status Examination
- VIII. Family History
  - Joint or nuclear family
  - Monthly income of the family

- Socio economic status
- Genogram
- IX. Personal History
  - a) Developmental history
  - b) Educational history
  - c) Occupational history pre-retirement
  - d) Source of income
    - Employment / pension / assistance from family/ other financial problems if any
  - e) Residence
    - Living at home/alone/with spouse/with children
    - Own / rented house
    - Any problems with living situation
- X. Marital History
  - Sexual /menstrual history
  - Genogram
  - Family history of mental or physical history
- XI. Premorbid personality
  - Specific traits
  - Social functioning
  - Occupational functioning
  - Biological functioning
  - Interest / hobbies, alcohol and other drug abuse
- XII. Community involvement
  - Members of organization / club / political activities/ voluntary work
- XIII. Social support
- XIV. Attitude towards ageing and death
- XV. Summary
- XVI. Investigations
- XVII. Treatment

### **REVIEW QUESTIONS**

- Describe nursing process in psychiatric nursing
- Describe various methods of assessment in psychiatry
- Mental status examination (Nov 2003, Oct 2004)

# 6

## *The Therapeutic Nurse-Patient Relationship*

- ❑ TYPES OF RELATIONSHIPS
- ❑ DIFFERENCES BETWEEN THERAPEUTIC AND SOCIAL RELATIONSHIP
- ❑ GOALS OF THERAPEUTIC RELATIONSHIP
- ❑ COMPONENTS OF THERAPEUTIC RELATIONSHIP
  - Rapport
  - Empathy
  - Warmth
  - Genuineness
- ❑ CHARACTERISTICS OF THERAPEUTIC NURSE-PATIENT RELATIONSHIP
- ❑ PHASES OF THERAPEUTIC RELATIONSHIP
  - Pre-interaction Phase
  - Introductory Phase
  - Working Phase
  - Termination Phase
- ❑ THERAPEUTIC COMMUNICATION TECHNIQUES
- ❑ PROCESS RECORDING

A relationship is defined as a state of being related or a state of affinity between two individuals. The nurse and client interact with each other in the health care system with the goal of assisting the client to use personal resources to meet his or her unique needs.

In a therapeutic relationship the nurse and client work together towards the goal of assisting the client to regain the inner resources to meet life challenges and facilitate growth. The interaction is purposefully established, maintained and carried out with the anticipated outcome of helping the client gain new coping and adaptation skills.

### **TYPES OF RELATIONSHIPS**

- Social relationships.
- Intimate relationships.
- Therapeutic relationships.

### **Social Relationships**

A social relationship can be defined as a relationship that is primarily initiated with the purpose of friendship, socialization, enjoyment or accomplishing a task. Mutual needs are met during social interaction. For example, participants share ideas, feelings and experiences.

### **Intimate Relationships**

An intimate relationship occurs between two individuals who have an emotional commitment to each other. Those in an intimate relationship usually react naturally with each other. Often the relationship is a partnership wherein each member cares about the other's need for growth and satisfaction.

### **Therapeutic Relationships**

The therapeutic relationship between nurse and client differs from both a social and an intimate relationship in that the nurse maximizes inner communication skills, understanding of human behavior and personal strengths, in order to enhance the client's growth. The focus of the relationship is on the client's ideas, experiences and feelings.

### **GOALS OF THERAPEUTIC RELATIONSHIP**

- Facilitating communication of distressing thoughts and feelings.
- Assisting the client with problem solving .
- Helping clients examine self-defeating behaviors and test alternatives.
- Promoting self-care and independence.

## DIFFERENCES BETWEEN THERAPEUTIC AND SOCIAL RELATIONSHIP

|                       | <i>Therapeutic relationship</i>  | <i>Social relationship</i>                             |
|-----------------------|--|--|
| <b>Technique</b>      | A planned therapeutic relationship   | Just happens with mutual interests                     |
| <b>Objective</b>      | Helping the patient  | Satisfying the needs of each other                     |
| <b>Duration</b>       | Usually time is limited  | Varies, may last for years                             |
| <b>Accountability</b> | Nurse is accountable for the goals of the relationship   | Both are responsible and accountable                   |
| <b>Acceptance</b>     | Nurse accepts patient as "here and now", without any personal or emotional attachments and interests | Personal/emotional attachment and interest involved    |
| <b>Termination</b>    | An important part of the relationship, it is planned and discussed with the patient                  | Relationship may exist lifelong or terminate gradually |

## COMPONENTS OF THERAPEUTIC RELATIONSHIP

### Rapport

Rapport is a relationship or communication especially when useful and harmonious. It is the crux of a therapeutic relationship between the nurse and the patient.

It is:

- a willingness to become involved with another person
- growth towards mutual acceptance and understanding of individuality
- the end result of one's care and concern for another.

The nurse establishes rapport through demonstration of understanding, warmth and non-judgmental attitude. A skilled nurse will be able to establish rapport that will alleviate the patient's problems. When rapport develops, the patient feels comfortable with the nurse and finds it easier to self-disclose. The nurse also feels comfortable and recognizes that an interpersonal bond or alliance is developing.

### Empathy

Empathy is an ability to feel with the patient while retaining the ability to critically analyze the situation.

It is the ability to put oneself in another person's circumstances and feelings. The nurse need not necessarily have to experience it, but has to be able to imagine the feelings associated with the experience.

In empathy process the nurse receives information from the patient with an open, non-judgemental acceptance, and communicates this understanding of the experience and feelings so that the patient feels understood. This serves as a basis for the relationship.

Sympathy is often confused with empathy. In sympathy, the nurse actually feels what the patient feels but in the process objectivity is lost, and the nurse becomes focused on relief of personal distress rather than on assisting the patient to resolve the problem. With empathy while understanding the patient's thoughts and feelings, the nurse is able to maintain sufficient objectivity to allow the patient to achieve problem resolution with minimal assistance.

### Warmth

Warmth is the ability to help the client feel cared for and comfortable. It shows acceptance of the client as a unique individual. It involves a non-possessive caring for the client as a person and a willingness to share the client's joys and sorrows.

### Genuineness

Genuineness involves being one's own self. This implies that the nurse is aware of her thoughts, feelings, values and their relevance in the immediate interaction with a client. The nurse's response to the client is sincere and reflects her internal response. It is also important that the nurse's verbal and non-verbal communication correspond with each other.

### CHARACTERISTICS OF THERAPEUTIC NURSE-PATIENT RELATIONSHIP

- The therapeutic relationship is the cornerstone of psychiatric-mental health nursing, where observation and understanding of behavior and communication are of great importance. It is a mutual learning experience, and a corrective emotional experience for the patient
- The nature of the therapeutic relationship is characterized by the mutual growth of individuals who "dare" to become related to discover love, growth and freedom.
- The therapeutic relationship is based on the belief that the patient has potential, and as a result of the relationship, "will grow to his fullest potential".
- In a therapeutic relationship the nurse and client work together towards the goal or assisting the client to regain the inner resources in order to meet life challenges and facilitate growth. The interaction is purposefully established, maintained and carried out with the anticipated outcome of helping the patient to gain new coping and adaptation skills.

### PHASES OF THERAPEUTIC RELATIONSHIP

Four phases of relationship process have been identified

- Pre-interaction phase
- Introductory or orientation phase
- Working phase
- Termination phase

### Pre-interaction Phase

This phase begins when the nurse is assigned to initiate a therapeutic relationship and includes all that the nurse thinks, feels or does immediately prior to the first interaction with the patient. The nurse's initial task is one of self-exploration. The nurse may have misconceptions and prejudices about psychiatric patients and may have feelings and fears common to all novices. Many nurses express feelings of inadequacy and fear of hurting or exploiting the patient. Another common fear of nurses is related to the stereotyped psychiatric patients' abusive and violent behavior.

The nurse should also explore feelings of inferiority, insecurity, approval-seeking behaviors etc. This self-analysis is a necessary task because, to be effective, she should have a reasonably stable self-concept and an adequate amount of self-esteem.

#### Nurse's tasks in the pre-interaction phase

- Explore own feelings, fantasies and fears
- Analyze own professional strengths and limitations
- Gather data about patient whenever possible
- Plan for first meeting with patient

#### Problems Encountered

- *Difficulty in self-analysis and self-acceptance:* Promoting a patient's self-realization and self-acceptance is facilitated by the nurse's acceptance of herself and behaving in ways congruent with her own personality. Also, the nurse should have enough sources of satisfaction and security in her non-professional life to avoid the temptations or using her patient for the pursuit of her personal satisfaction or security. If she does not have sufficient personal fulfillment she should realize it and the source of dissatisfaction clarified, so that it does not interfere with the success of the therapeutic relationship.
- *Anxiety:* Quite frequently, the nurse may experience anxiety of varying intensity during the pre-interaction phase due to role threat, feelings of incompetence, fear of being hurt or

- of causing distress, fear of losing control and fear of rejection. The nurse needs to become aware of what is being experienced, identify the threat, and decide what needs to be done about it. This is important, so that the patient is not unduly affected by the nurse's anxiety.
- Apart, from anxiety, the nurse may also experience *boredom, anger, indifference, and depression*. The cause of such feelings must be identified, which is the first step in devising ways to cope with them.

### Ways to Overcome

- The nurse needs help from her supervisor and peers in self-analysis and facing reality in order to help patients do likewise. This provides opportunity to explore feelings and fears and develops useful insight into one's professional role.
- It is also helpful to conceptualize in advance what she wishes to accomplish during the relationship. The nurse may in consultation with her supervisor identify in writing goals for the initial interaction, and decide the methods to be used in achieving the goals.
- The nurse also needs to be consciously aware of the reasons for choosing a particular patient. She may also attempt to assess the patient's anxiety level as well as her own. The nurse who is able to analyze herself and recognize her assets and limitations, is able to use this information in relating to patients in a natural, congruent and relaxed manner.

### Introductory or Orientation Phase

It is during the introductory phase that the nurse and patient meet for the first time. One of the nurse's primary concerns is to find out why the patient sought help. This forms the basis of the nursing assessment and helps the nurse to focus on the patient's problem and to determine patient's level of motivation.

#### Nurse's tasks in the orientation phase

- Establish rapport, trust and acceptance
- Establish communication; assist in the verbal expression of thoughts and feelings

- Gather data, including the client's feelings, strengths and weaknesses
- Define client's problems; set priorities for nursing intervention
- Mutually set goals

### Problems Encountered

- The major problem encountered during this phase is related to the manner in which the nurse and patient perceive each other. A nurse may react to a patient not in terms of his uniqueness, but in terms of the nurse's stereotyped view of a "psychiatric patient," or she may because of her theoretical background read in terms of diagnostic categories. Sometimes the nurse may relate to a patient as if he were a significant individual from the past. The nurse may then displace to the patient the feelings she has for the significant individual. Since interaction is a reciprocal process, the patient also perceives the nurse in his own idiosyncratic manner. Thus, *perception of each other as unique individuals may not take place*.
- *Problems related to establishing an agreement or pact between the nurse and patient:* The patient may feel that since the nurse is here only for a few weeks much help cannot be expected from her in the short span of time. The same feelings may be experienced by the nurse, in that she feels she cannot do much for the patient during his stay in the hospital due to factors like limited time, overwork or the nurse's opinion that the patient is suffering from a 'major psychiatric problem'. Because the establishment of an agreement or pact to work together is a mutual process, such misperceptions can greatly hinder it.

### Ways to Overcome

- The nurse must be willing to relate honestly to her perceptions, thoughts and feelings, and to share the data collected during the nurse-patient interaction with her supervisors. The supervisor must provide an atmosphere in which the nurse feels free to reveal self without any fear of criticism.

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- Difficulties may be faced in assisting a nurse who perceives a patient as if he were someone from her past life. She is usually not aware of doing so, since most of this behavior is unconsciously determined. An alert supervisor can usually detect that the nurse is distorting the patient by viewing him as someone else. It may be necessary to bring the problem to the nurse's attention so that she can examine her behavior. Gradually, with assistance the nurse is able to audit her behavior, and then to change it.

### Working Phase

Most of the therapeutic work is carried out during the working phase. The nurse and the patient explore relevant stressors and promote the development of insight in the patient. By linking perceptions, thoughts, feelings and actions, the nurse helps the patient to master anxieties, increase independence and coping mechanisms. Actual behavioral change is the focus of attention in this phase of the relationship.

### Nurse's tasks in the working phase

- Gather further data; explore relevant stressors
- Promote patient's development of insight and use of constructive coping mechanisms
- Facilitate behavioral change; encourage him to evaluate the results of his behavior
- Provide him with opportunities for independent functioning
- Evaluate problems and goals and redefine as necessary

### Problems Encountered

- Testing of the nurse by the patient:* The patient may test the nurse in a number of ways, and for a number of reasons. For example, he may wish to check her ability to set limits and abide by them. A patient with problems related to aggression may deliberately attempt to provoke the nurse to determine whether or not she will become punitive.
- Progress of the patient:* Another barrier is the nurse's unrealistic assumption as to the progress the patient should be making. It is

common for the patient to show desirable behavioral changes in the beginning, and then remain fixed, neither progressing nor regressing. A nurse who was enthusiastic about the patient's improvement may then become discouraged when he does not progress at a steady state.

- The nurse's fear of closeness:* If the nurse fears closeness too much, she may react by being indifferent, rejecting or being cold towards the patient. She must learn to interact with kindness and concern, but with objectivity and professional interest.
- Life stresses of the nurse:* A nurse who has difficulty in coping with her own life problems cannot help a patient in making appropriate behavioral changes.
- Resistance behaviors:* Resistance is the patient's attempt to remain unaware of anxiety-producing aspects within him. Resistance may take different forms and some of them were identified by Wolfberg as follows:
  - Suppression and repression of relevant information
  - Intensification of symptoms
  - A helpless outlook on the future
  - Breaking appointments, coming late to his sessions, being forgetful, silent and sleepy during the interactions
  - Acting out or irrational behavior
  - Expressing an excessive liking for the nurse and claiming that nobody can replace her
  - Reporting physical symptoms which may occur only during the time the client is with the nurse
  - Hostility, dependence, provocative remarks, sexual interest in the nurse
- Transference and counter transference reactions:* These are in fact a form of resistance behavior. Transference is the unconscious transfer of qualities or attributes originally associated with another individual by the patient. Transference occurs because the patient brings frustrations, conflicts and feelings of dependence from a past relationship into the

therapeutic relationship. The patient may express feelings of aggression, rejection or hostility that are too intense for the current situation. These responses are often not appropriate for the nurse-patient relationship. Counter transference is the reverse of transference. The nurse may have unresolved problems from an earlier relationship. She may unconsciously transfer inappropriate attributes to a client that was experienced in that earlier relationship. The client's transference provokes the nurse's counter transference reactions.

### Ways to Overcome

- Conferences with the supervisors and group discussions with other members of the staff are the ways in which the nurse can best be assisted to overcome the barriers encountered during the working phase. It is during this phase that the supervisor helps the nurse to increase her ability to collect and interpret data, apply concepts and synthesize the data obtained.
- There will be times when the nurse believes she is making little or no progress, either in helping the patient or in gaining knowledge. It is at such times that emotional support is needed, and it is the task of the supervisor to encourage the nurse to persevere.
- At one time or another, most nurses may exhibit a reluctance to write and analyze process records or to engage in a discussion with the supervisor about the content of records, due to many reasons. For instance fatigue, boredom, discouragement or an apparent impasse in interacting with a patient may cause reluctance. A discussion of the meaning of behavior and of ways to overcome it is essential.
- Handling resistances: The nurse may find the experience of transference and counter transference particularly difficult. The relationship can become stalled and non-beneficial if the nurse is not prepared for the patient's expression of feelings or is so preoccupied by

her own needs and problems that she cannot clearly perceive what is happening.

- The first thing the nurse must do in handling resistance is to listen. When she recognizes the resistance, she then uses clarification and reflection of feelings; clarification helps to give the nurse a more focused idea of what is happening, while reflection of content helps the patient to become aware of what has been going on in his own mind.
- It is not sufficient to merely identify that resistance is occurring; the behavior must be explored and possible reasons for its occurrence analyzed. Ignoring transference can perpetuate the pattern. Also, being overly critical of the patient, withholding information or being over involved in making decisions for the patient can encourage the dysfunctional behavioral pattern. It is important that the nurse maintains open communication with her supervisor, who can then guide her in making adequate progress in handling such resistance reactions.

### Termination Phase

This is the most difficult, but most important phase of the therapeutic nurse-patient relationship. The goal of this phase is to bring a therapeutic end to the relationship.

#### Criteria for determining patient's readiness for termination:

- Patient experiences relief from presenting problems
- Patient's social function has improved and isolation has decreased
- Patient's ego functions are strengthened and he has attained a sense of identity
- Patient employs more effective and productive defense mechanisms
- Patient has achieved the planned treatment goals

#### Nurse's tasks in the termination phase:

- Establish reality of separation
- Mutually explore feelings of rejection, loss, sadness, anger and related behavior

- Review progress of therapy and attainment of goals
- Formulate plans for meeting future therapy needs

### Problems Encountered

- It is the task of the nurse to prepare the patient for termination of the relationship.

However, patients differ in their reactions to the nurse's attempts to prepare them for termination. An ill person who has experienced trust, support and the warmth of caring may be reluctant to discontinue the nurse-patient contact.

Some behaviors exhibited in this regard can be:

- Patients may perceive termination as desertion and may demonstrate angry behavior
- Some patients attempt to punish the nurse for this desertion by not talking during the last few interactions or by ignoring termination completely; they may act as if nothing has changed and the interactions will go on as before
- Other patients react to the threatened loss by becoming depressed or assuming an attitude of not caring
- Fault-finding is another behavior; the client may state that the therapy is not beneficial or not working; he may refuse to follow through on something that has been agreed upon before
- Resistance often comes in the form of "flight to health", which is exhibited by a patient who suddenly declares that there is no need for therapy; he claims to be all right and wants to discontinue the therapeutic relationship; this may be a form of denial or fear of the anticipated grief over separation
- "Flight to illness" occurs when a client exhibits sudden return of symptoms; this is an unconscious effort to show that termination is inappropriate and that the nurse is still needed; the client may disclose new information about him or more problems or even threaten to commit suicide in an attempt to delay parting
- The barriers to goal accomplishment during this phase also seem to be related to the nurse's inability or unwillingness to make specific

plans and implement them. Plans for termination are essential and the nurse needs to conceptualize these plans in advance. A nurse who does not discuss frankly the reasons for termination or elicit from the patient his thoughts and feelings about the impending termination cannot help to prepare him psychologically. Similarly, a nurse who cannot explore her own thoughts and feelings about separation from the patient is also unable to accomplish the goals related to termination.

### Ways to Overcome

- The nurse should be aware of the patient's feelings and be able to deal with them appropriately. The nurse can assist the patient by openly eliciting his thoughts and feelings about termination. For some patients, termination is a critical experience, because many of their past relationships were terminated in a negative way that left them with unresolved feelings of abandonment, rejection, hurt and anger. Learning to bear the sorrow of the loss while incorporating positive aspects of the relationship into one's life is the goal of termination in the therapeutic nurse patient relationship.
- During this phase, the supervisor may notice that the nurse is showing less interest in the patient than shown earlier and may be disengaging self from the patient several days before the final interaction. This may be a psychological defense mechanism by which she tries to decrease or delay the anxiety she is experiencing as a result of the impending termination of relationship. The task of the supervisor is to discuss frankly with the nurse the meaning of the behavior. The supervisor then initiates action to assist the nurse to persevere and intensify her efforts to prepare both self and patient for his eventual release from the hospital.

### THERAPEUTIC COMMUNICATION TECHNIQUES

1. **Listening:** It is an active process of receiving information. Responses on the part of the

nurse such as maintaining eye-to-eye contact, nodding, gesturing and other forms of receptive non-verbal communication convey to the patient that he is being listened to and understood.

*Therapeutic value* Non-verbally communicates to the patient the nurse's interest and acceptance.

2. **Broad openings:** Encouraging the patient to select topics for discussion. For example, "What are you thinking about?"

*Therapeutic value* Indicates acceptance by the nurse and the value of patient's initiative.

3. **Restating:** Repeating the main thought expressed by the patient. For example, "You say that your mother left you when you were five years old."

*Therapeutic value* Indicates that the nurse is listening and validates, reinforces or calls attention to something important that has been said.

4. **Clarification:** Attempting to put vague ideas or unclear thoughts of the patient into words to enhance the nurse's understanding or asking the patient to explain what he means. For example, "I am not sure what you mean. Could you tell me about that again?"

*Therapeutic value* It helps to clarify feelings, ideas and perceptions of the patient and provides an explicit correlation between them and the patient's actions.

5. **Reflection:** Directing back the patient's ideas, feelings, questions and content. For example "You are feeling tense and anxious and it is related to a conversation you had with your husband last night."

*Therapeutic value* Validates the nurse's understanding of what the patient is saying and signifies empathy, interest and respect for the patient.

6. **Humor:** The discharge of energy through comic enjoyment of the imperfect. For example, "That gives a whole new meaning to the word 'nervous', " said with shared kidding between the nurse and the patient.

*Therapeutic value* Can promote insight by making repressed material conscious, resolving paradoxes, tempering aggression and revealing new options, and is a socially acceptable form of sublimation.

7. **Informing:** The skill of information giving. For example, "I think you need to know more about your medications."

*Therapeutic value* Helpful in health teaching or patient education about relevant aspects of patient's well-being and self-care.

8. **Focusing:** Questions or statements that help the patient expand on a topic of importance. For example, "I think that we should talk more about your relationship with your father."

*Therapeutic value* Allows the patient to discuss central issues and keeps the communication process goal-directed.

9. **Sharing perceptions:** Asking the patient to verify the nurse's understanding of what the patient is thinking or feeling. For example, "You are smiling, but I sense that you are really very angry with me."

*Therapeutic value* Conveys the nurse's understanding to the patient and has the potential for clearing up confusing communication.

10. **Theme identification:** This involving identification of underlying issues or problems experienced by the patient that emerge repeatedly during the course of the nurse-patient relationship. For example, "I noticed that you said you have been hurt or rejected by the man. Do you think this is an underlying issue?"

*Therapeutic value* It allows the nurse to promote the patient's exploration and understanding of important problems.

11. **Silence:** Lack of verbal communication for a therapeutic reason. For example, sitting with a patient and non-verbally communicating interest and involvement.

*Therapeutic value* Allows the patient time to think and gain insight, slows the pace of the interaction and encourages the patient to initiate conversation while enjoying the nurse's support, understanding and acceptance.

**12. Suggesting:** Presentation of alternative ideas for the patient's consideration relative to problem solving. For example, "Have you thought about responding to your boss in a different way when he raises that issue with you? You could ask him if a specific problem has occurred."

*Therapeutic value* Increases the patient's perceived notions or choices.

### PROCESS RECORDING

Recording is an important and necessary function of any organization whether it is an industry, a business enterprise, a hospital or for that matter even farming. Recording is done in different ways in different organizations and situations. Process recording is the method of recording used in psychiatric wards by nurses.

**Definition:** Process recording is a written account or verbatim recording of all that transpired, during and immediately following the nurse-patient interaction. In other words, it is the recording of the conversation during the interaction or the interview between the nurse and the patient in the psychiatric setup with the nurse's inference. It may be written during the interaction or immediately after the one-to-one interaction.

**Purpose and uses:** The aim of process recording is to improve the quality of the interaction for better effect to the patient and as a learning experience for the nurse to continuously improve her clinical interaction pattern. When correctly used, it

- assists the nurse or student to plan, structure and evaluate the interaction on a conscious rather than an intuitive level;
- assists her to gain competency in interpreting and synthesizing raw data under supervision;
- helps to consciously apply theory to practice;
- helps her to develop an increased awareness of her habitual, verbal and non-verbal communication pattern and the effect of those patterns on others;
- helps the nurse to learn to identify thoughts and feelings in relation to self and others;

- helps to increase observational skills, as there is a conscious process involved in thinking, sorting and classifying the interaction under the various headings;
- helps to increase the ability to identify problems and gain skills in solving them; After a few exercises these skills will become so in-built that she will keep using them automatically even when it is not specifically required or when she does not have the time to do it.

Thus process recording is a/an

- Educative tool
- Teaching tool
- Diagnostic tool
- Therapeutic tool, and a pre-requisite for nursing process

### Pre-requisites for Process Recording

- Physical setting
- Getting consent of the patient for the possibility of cassette recording
- Confidentiality

### Suggested Outlines for Process Recording

#### *Introductory Material*

This should include a short description of the patient, his name, age, educational level, health problems and length of stay in the hospital. The date, time, place of interaction and a short description of the milieu of the ward immediately prior to the interaction will be helpful in understanding the thoughts and feelings of the patient. It is also helpful to record the thoughts and feelings of the nurse just before the interaction. Reason for choosing the patient and the duration of the nurse-patient relationship should also be included. To understand the patient in a better way, process recording also includes personal history, family history, socio-economic history, medical history, present complaints, past psychiatric history if any, and provisional diagnosis.

#### *Objectives*

They can be different on different days of the interview. For example, in the beginning, setting short-term goals may be more appropriate. In the

**VERBATIM**

PLACE

DATE AND TIME

SITUATION

DATE OF ADMISSION

OBJECTIVES OF THE INTERVIEW

(1)

(2)

(3)

| <i>Person</i> | <i>Verbatim</i> | <i>Non-verbal<br/>Communication</i> | <i>Inference</i> |
|---------------|-----------------|-------------------------------------|------------------|
|               |                 |                                     |                  |

Conclusion— Fixing the time and place for the next interview.

Summary— List of inferences

Care plans made according to inference

Any special difficulties faced during the inference

Techniques used to overcome difficulties

**SIGNATURE**

second stage (working phase) the objectives can be more long-term in nature, focusing on corrective psychodynamics, including rehabilitation, follow-up and preparing the family for future plans.

***Record of Interaction between Nurse  
and the Patient***

This should include truthful recording of what

the nurse said and did and what the patient said and did, including any non-verbal behavior of the patient, such as changing the position, looking at various things, eye contact, biting the nails, pacing, etc. What the nurse did also means all her non-verbal behavior. The nurse's thoughts and feelings also should be recorded so that a self-evaluation can be made as to how these influence her behavior.

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### *Analysis of the Interaction*

An analysis of the interaction should include the interpretation of the verbal and non-verbal behavior and patient's thoughts and feelings as evident from the process. The communication techniques used by the nurse and evaluation of the technique in terms of its effect on the patient and in terms of the planned objectives also should be included. The nurse's thoughts and feelings at the end of the interaction and the plans made for further interactions should be stated.

Process recording can be written as short notes during the interaction and rewritten immediately after it. Total time spent on the recording can be around 30 minutes. The active time can be 20 minutes, with 10 minutes for conclusion and recording. Although video or tape recorders give more accurate recording, the impact of this equipment on the interaction will make an unnatural influence.

### **REVIEW QUESTIONS**

- Types of relationship

- Difference between therapeutic and social relationship
- Goals of therapeutic relationship (Apr 2004)
- Nurse-patient relationship (Apr 2002)
- List the characteristics of therapeutic nurse-patient relationship (Nov 2003)
- Phases of therapeutic relationship and the role during each phase (Feb 2000, Feb 2001, Apr 2006, Oct 2006)
- Explain the problems commonly encountered by the nurse while developing such relationship (Nov 2003)
- Working phase (Oct 2005)
- Counter transference (Apr 2005)
- Therapeutic communication techniques
- Listening as a tool of communication (Apr 2002)
- Process recording (Nov 1999, Feb 2000, Nov 2002, Nov 2003, Apr 2004, Oct 2004, Oct 2005, Apr 2006)
- Rapport and resistance (Oct 2000, Oct 2006)
- Empathy and Sympathy (Oct 2000, Nov 2003)

# 7

# The Individual with Functional Psychiatric Disorder

- SCHIZOPHRENIA
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  - Nursing Management of Major Depressive Episode

from the Greek words *skhizo* (split) and *phren* (mind).

In ICD10, schizophrenia is classified under code F2.

## Definition

Schizophrenia is a psychotic condition characterized by a disturbance in thinking, emotions, volitions and faculties in the presence of clear consciousness, which usually leads to social withdrawal.

## Epidemiology

Schizophrenia is the most common of all psychiatric disorders and is prevalent in all cultures across the world. About 15% of new admissions in mental hospitals are schizophrenic patients. It has been estimated that patients diagnosed as having schizophrenia occupy 50% of all mental hospital beds.

About three to four per 1000 in every community suffer from schizophrenia. About one percent of the general population stands the risk of developing this disease in their lifetime.

Schizophrenia is equally prevalent in men and women. The peak ages of onset are 15 to 25 years for men and 25 to 35 years for women.

About two-thirds of cases are in the age group of 15 to 30 years.

The disease is more common in lower socio-economic groups.

## Etiology

The cause of schizophrenia is still uncertain. Some of the factors involved may be:

## SCHIZOPHRENIA

The word 'Schizophrenia' was coined in 1908 by the Swiss psychiatrist Eugen Bleuler. It is derived

### Genetic Factors

The disease is more common among people born of consanguineous marriages. Studies show that relatives of schizophrenics have a much higher probability of developing the disease than the general population. The prevalence rate among family members of schizophrenics is as follows:

- Children with one schizophrenic parent: 12%
- Children with both schizophrenic parents: 40%
- Siblings of schizophrenic patient: 8%
- Second-degree relatives: 5-6%
- Dizygotic twins of schizophrenic patients: 12%
- Monozygotic twins of schizophrenic patients: 47%

### Stress-Diathesis Model

According to the stress-diathesis model for the integration of biological, psychosocial and environmental factors, a person may have a specific vulnerability (diathesis) that, when acted on by a stressful influence, allows the symptoms of schizophrenia to develop. In the most general stress-diathesis model, the diathesis or the stress can be biological, environmental or both. The environmental component again can be either biological (e.g. an infection) or psychological (e.g. stressful family situation). The biological basis of a diathesis can be further shaped by epigenetic influences such as substance abuse, psychosocial stress and trauma.

### Biochemical Factors

*Dopamine hypotheses:* This theory suggests that an excess of dopamine-dependent neuronal activity in the brain may cause schizophrenia.

*Other biochemical hypotheses:* Various other biochemicals have been implicated in the predisposition to schizophrenia. These include abnormalities in the neurotransmitters norepinephrine, serotonin, acetylcholine and gamma-aminobutyric acid (GABA), and neuroregulators such as prostaglandins and endorphins.

### Psychological Factors

Family relationships act as major influence in the development of illness:

*Mother-child relationship:* Early theorists characterized the mothers of schizophrenics as cold, over-protective, and domineering, thus retarding the ego development of the child.

*Dysfunctional family system:* Hostility between parents can lead to a schizophrenic daughter (marital skew and schism).

*Double-bind communication* (Bateson et al, 1956): Parents convey two or more conflicting and incompatible messages at the same time.

### Social Factors

Studies have shown that schizophrenia is more prevalent in areas of high social mobility and disorganization, especially among members of very low social classes. Stressful life events also can precipitate the disease in predisposed individuals.

### Schneider's First-Rank Symptoms of Schizophrenia (SFRS)

Kurt Schneider proposed the first rank symptoms of schizophrenia in 1959. The presence of even one of these symptoms is considered to be strongly suggestive of schizophrenia. They include:

- Hearing one's thoughts spoken aloud (audible thoughts or thought echo).
- Hallucinatory voices in the form of statement and reply (the patient hears voices discussing him in the third person).
- Hallucinatory voices in the form of a running commentary (voices commenting on one's action).
- Thought withdrawal (thoughts cease and subject experiences them as removed by an external force).
- Thought insertion (subject experiences thoughts imposed by some external force on his passive mind).
- Thought broadcasting (subject experiences that his thoughts are escaping the confines of

- his self and are being experienced by others around).
- Delusional perception (normal perception has a private and illogical meaning).
- Somatic passivity (bodily sensations especially sensory symptoms are experienced as imposed on body by some external force).
- Made volition or acts (one's own acts are experienced as being under the control of some external force, the subject being like a robot).
- Made impulses (the subject experiences impulses as being imposed by some external force).
- Made feelings or affect (the subject experiences feelings as being imposed by some external force).

### Clinical Features

The predominant clinical features in acute schizophrenia are *delusions*, *hallucinations* and *interference with thinking*. Features of this kind are often called positive symptoms or psychotic features while most of the patients recover from acute illness, some progress to the chronic phase, during which time the main features are *affective flattening* or *blunting*, *avolition-apathy* (lack of initiative), *attentional impairment*, *anhedonia* (inability to experience pleasure), *asociality*, *alogia* (lack of speech output). These are called as negative symptoms. Once the chronic syndrome is established, few patients recover completely.

The signs and symptoms commonly encountered in schizophrenic patients may be grouped as follows:

#### *Thought and Speech Disorders*

- Autistic thinking (preoccupations totally removing a person from reality).
- Loosening of associations (a pattern of spontaneous speech in which the things said in juxtaposition lack a meaningful relationship with each other).
- Thought blocking (a sudden interruption in the thought process).
- Neologism (a word newly coined, or an everyday word used in a special way, not readily

- understood by others).
- Poverty of speech (decreased speech production).
- Poverty of ideation (speech amount is adequate but content conveys little information).
- Echolalia (repetition or echo by patient of the words or phrases of examiner).
- Perseveration (persistent repetition of words or themes beyond the point of relevance).
- Verbigeration (senseless repetition of some words or phrases over and over again).
- Delusions of various kinds i.e., delusions of persecution (being persecuted against); delusions of grandeur (belief that one is especially very powerful, rich, born with a special mission in life); delusions of reference (being referred to by others); delusions of control (being controlled by an external force); somatic delusions.
- Other thought disorders are over inclusion (tending to include irrelevant items in speech), impaired abstraction, concreteness and ambivalence.

#### *Disorders of Perception*

- Auditory hallucinations (described under SFRS).
- Visual hallucinations may sometimes occur along with auditory hallucinations; tactile, gustatory and olfactory types are far less common.

#### *Disorders of Affect*

These include apathy, emotional blunting, emotional shallowness, anhedonia and inappropriate emotional response. The incapacity of the patient to establish emotional contact leads to lack of rapport with the examiner.

#### *Disorders of Motor Behavior*

There can be either an increase or a decrease in psychomotor activity. Mannerisms, grimacing, stereotypes, decreased self-care and poor grooming are common features.

### Other Features

- Decreased functioning in work, social relations and self-care, as compared to earlier life.
- Loss of ego boundaries.
- Loss of insight.
- Poor judgment.
- Suicide can occur due to the presence of associated depression, command hallucinations, impulsive behavior, or return of insight that causes the patient to comprehend the devastating nature of the illness and take his life.
- There is usually no disturbance of consciousness, orientation, attention, memory and intelligence.
- There is no underlying organic cause.

### Clinical Types

Schizophrenia can be classified into the following subtypes:

1. Paranoid
2. Hebeephrenic (disorganized)
3. Catatonic
4. Residual
5. Undifferentiated
6. Simple
7. Post-schizophrenic depression

#### *Paranoid Schizophrenia*

The word 'paranoid' means 'delusional.' Paranoid schizophrenia is at present the most common form of schizophrenia. It is characterized by the following features (in addition to the general features already described).

- *Delusions of persecution:* In persecutory delusions, individuals believe that they are being malevolently treated in some way. Frequent themes include being conspired against, cheated, spied upon, followed, poisoned or drugged, maliciously maligned, harassed or obstructed in the pursuit of long-term goals.
- *Delusions of jealousy:* The content of jealous delusions centers around the theme that the person's sexual partner is unfaithful. The idea is held on inadequate grounds and is unaffected by rational judgment.

- *Delusions of grandiosity:* Individuals with grandiose delusions have irrational ideas regarding their own worth, talent, knowledge or power. They may believe that they have a special relationship with famous persons, or grandiose delusions of a religious nature may lead to assumption of the identity of a great religious leader.
- Hallucinatory voices that threaten or command the patient, or auditory hallucinations without verbal form, such as whistling, humming and laughing.
- Other features include disturbance of affect (though affective blunting is less than in other forms of schizophrenia), volition, speech and motor behavior.

Paranoid schizophrenia has a good prognosis if treated early. Personality deterioration is minimal and most of these patients are productive and can lead a normal life.

#### *Hebeephrenic (disorganized) Schizophrenia*

It has an early and insidious onset and is often associated with poor premorbid personality. The essential features include marked thought disorder, incoherence, severe loosening of associations and extreme social impairment. Delusions and hallucinations are fragmentary and changeable. Other oddities of behavior include senseless giggling, mirror-gazing, grimacing, mannerisms and so on. The course is chronic and progressively downhill without significant remissions. Recovery classically never occurs and it has one of the worst prognoses among all the subtypes.

#### *Catatonic Schizophrenia*

Catatonic (Cata-disturbed) schizophrenia is characterized by marked disturbance of motor behavior. This may take the form of catatonic stupor, catatonic excitement and catatonia alternating between excitement and stupor.

#### *Clinical features of excited catatonia:*

- Increase in psychomotor activity (ranging from restlessness, agitation, excitement, aggressiveness to at times violent behavior).

- Increase in speech production.
- Loosening of associations and frank incoherence.

Sometimes excitement becomes very severe and is accompanied by rigidity, hyperthermia and dehydration and can result in death. It is then known as *acute lethal catatonia* or *pernicious catatonia*.

*Clinical features of retarded catatonia (catatonic stupor):*

- Mutism: Absence of speech.
- Rigidity: Maintenance of rigid posture against efforts to be moved.
- Negativism: A motiveless resistance to all commands and attempts to be moved, or doing just the opposite.
- Posturing: Voluntary assumption of an inappropriate and often bizarre posture for long periods of time.
- Stupor: Does not react to his surroundings and appears to be unaware of them.
- Echolalia: Repetition or mimicking of phrases or words heard.
- Echopraxia: Repetition or mimicking of actions observed.
- Waxy flexibility: Parts of body can be placed in positions that will be maintained for long periods of time, even if very uncomfortable (flexible like wax).

- Ambitendency: A conflict to do or not to do, e.g., on asking to put out tongue, it is slightly protruded but taken back again.
- Automatic obedience: Obeys every command irrespective of their nature.

#### *Residual Schizophrenia*

Symptoms of residual schizophrenia include emotional blunting, eccentric behavior, illogical thinking, social withdrawal and loosening of associations. This category should be used when there has been at least one episode of schizophrenia in the past but without prominent psychotic symptoms at present.

#### *Undifferentiated Schizophrenia*

This category is diagnosed either when features of no subtype are fully present or features of more than one subtype are exhibited.

#### *Simple Schizophrenia*

It is characterized by an early and insidious onset, progressive course, presence of characteristic negative symptoms, vague hypochondriacal features, wandering tendency, self-absorbed idleness and aimless activity. It differs from residual schizophrenia in that there never has been an episode with all the typical psychotic symptoms. The prognosis is very poor.

### **Prognostic Factors in Schizophrenia**

| <i>Good prognostic factors</i>   | <i>Poor prognostic factors</i>  |
|--|---|
| <ol style="list-style-type: none"> <li>1. Abrupt or acute onset</li> <li>2. Later onset</li> <li>3. Presence of precipitating factor</li> <li>4. Good premorbid personality</li> <li>5. Paranoid and catatonic subtypes</li> <li>6. Short duration: (&lt;6 months)</li> <li>7. Predominance of positive symptoms</li> <li>8. Family history of mood disorders</li> <li>9. Good social support</li> <li>10. Female sex</li> <li>11. Married</li> <li>12. Out-patient treatment</li> </ol> | <ol style="list-style-type: none"> <li>1. Insidious onset</li> <li>2. Younger onset</li> <li>3. Absence of precipitating factor</li> <li>4. Poor premorbid personality</li> <li>5. Simple, undifferentiated subtypes</li> <li>6. Long duration: (&gt;2 years)</li> <li>7. Predominance of negative symptoms</li> <li>8. Family history of schizophrenia</li> <li>9. Poor social support</li> <li>10. Male sex</li> <li>11. Single, divorced or widowed</li> <li>12. Institutionalization</li> </ol> |

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### *Post-schizophrenic Depression*

Depressive features develop in the presence of residual or active features of schizophrenia and are associated with an increased risk of suicide.

### **Course and Prognosis**

The classic course is one of exacerbations and remissions. In general, schizophrenia has been described as the most crippling and devastating of all psychiatric illnesses. Several studies have found that over the 5-10 years period after the first psychiatric hospitalization for schizophrenia, only about 10 to 20% of patients can be described as having a good outcome. More than 50% of patients have a poor outcome, with repeated hospitalizations.

### **Treatment**

#### *Pharmacotherapy*

An acute episode of schizophrenia typically responds to treatment with classic antipsychotic agents, which are most effective in its treatment. Some commonly used drugs include:

Chlorpromazine: 300–1500 mg/day PO; 50–100 mg/day IM

Fluphenazine decanoate: 25–50 mg IM every 1–3 weeks

Haloperidol: 5–100 mg/day PO; 5–20 mg/day IM

Trifluoperazine: 15– 60 mg/day PO ; 1–5 mg/day IM

Clozapine: 25–450 mg/day PO

Risperidone: 2–10 mg/day PO

Olanzapine: 10–20 mg/day PO

(Refer chapter 14 for a detailed description of these drugs).

### *Electroconvulsive Therapy (ECT)*

Indications for ECT in schizophrenia include:

- Catatonic stupor
- Uncontrolled catatonic excitement
- Severe side-effects with drugs

- Schizophrenia refractory to all other forms of treatment
- Usually 8-12 ECTs are needed

### *Psychological Therapies*

*Group therapy* The social interaction, sense of cohesiveness, identification, and reality testing achieved within the group setting have proven to be highly therapeutic for these individuals.

*Behavior therapy* Behavior therapy is useful in reducing the frequency of bizarre, disturbing and deviant behavior, and increasing appropriate behaviors.

*Social skills training* Social skills training addresses behaviors such as poor eye contact, odd facial expressions and lack of spontaneity in social situations through the use of videotapes, role playing and homework assignments.

*Cognitive therapy* Used to improve cognitive distortions like reducing distractibility and correcting judgment.

*Family therapy* Family therapy typically consists of a brief program of family education about schizophrenia. It has been found that relapse rates of schizophrenia are higher in families with high expressed emotions (EE), where significant others make *critical comments, express hostility* or show *emotional over-involvement*. The significant others are, therefore, taught to decrease expectations and family tensions, apart from being given social skills training to enhance communication and problem solving.

### *Psychosocial Rehabilitation*

This includes activity therapy to develop the work habit, training in a new vocation or retraining in a previous skill, vocational guidance and independent job placement.

### **Nursing Management**

#### *Nursing Assessment*

Assessment of the schizophrenic patient may be a complex process, based on information gathered

**Table 7.1:** Nursing interventions for delusional behaviour

| Interventions  | Rationale   |
|--|---|
| (a) Convey acceptance of the patient's need for the false belief, but that you do not share the belief.<br>(b) Do not argue or deny the belief.  | The client must understand that you do not view the idea as real.   |
| (c) Reinforce and focus on reality. Discourage long discussions about the irrational thinking. Instead talk about real events and real people.   | Arguing or denying serves no useful purpose as delusional ideas are not eliminated by this approach; further, this may adversely affect the development of a trusting relationship. |
| (d) If the client is highly suspicious, the following interventions may help:<br>* use same staff as far as possible;<br>be honest and keep all promises<br>* avoid physical contact in the form of touching the patient etc;<br>* avoid laughing, whispering or talking quietly where the client can see but cannot hear what is being said;<br>* avoid competitive activities; use assertive, matter-of-fact yet friendly approach | Discussions that focus on the false ideas are purposeless and useless and may even aggravate the condition.   |
|  | To promote trust  |
|  | To prevent the client from feeling threatened   |
|  | -do-  |
|  | -do-  |

from a number of sources. Schizophrenic patients in an acute episode of the illness are seldom able to make a significant contribution to their history. Data may be obtained from family members if possible, old records if available, or from other individuals who are in a position to report on the progression of the patient's behavior.

evidenced by inappropriate responses, disordered thought process, poor concentration and disorientation.

*Objective:* Patient will be able to define and test reality, eliminating the occurrence of hallucinations.

*Intervention:* See Table 7.2.

#### Nursing Diagnosis

Alteration in thought processes related to inability to trust, panic anxiety, evidenced by delusional thinking, inability to concentrate, impaired volition, extreme suspiciousness of others.

*Objective:* Patient will eliminate patterns of delusional thinking and demonstrate trust in others

*Intervention:* See Table 7.1.

#### Nursing Diagnosis III

Social isolation related to inability to trust, panic anxiety, delusional thinking, evidenced by withdrawal, sad, dull affect, preoccupation with own thoughts, expression of feelings of rejection of aloneness imposed by others.

*Objective:* Patient will voluntarily spend time with other patients and staff members in group activities on the unit.

*Intervention:* See Table 7.3.

#### Nursing Diagnosis II

Sensory-perceptual alteration: Auditory/visual, related to panic anxiety, withdrawal into self,

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**Table 7.2:** Nursing interventions for hallucinatory behaviour

| <i>Interventions</i>  | <i>Rationale</i>   |
|---|--|
| (a) Observe the client for signs of hallucinations (listening pose, laughing or talking to self, stopping in mid-sentence).   | Early intervention may prevent aggressive response to command hallucinations.                      |
| (b) Avoid touching the client without warning.  | The client may perceive touch as threatening and may respond in an aggressive manner.              |
| (C) An attitude of acceptance will encourage the patient to share the content of the hallucination with you.  | This is important to prevent possible injury to the patient or others from command hallucinations. |
| (d) Do not reinforce the hallucinations. Use "the voices" instead of words like "they" that imply validation. Say "Even though I realize the voices are real to you, I don't hear any voices speaking." | The client should know that you do not share the false perception.                                 |
| (e) Help the client understand the connection between anxiety and hallucinations.   | If the client can learn to interrupt rising anxiety, hallucinations may be prevented.              |
| (f) Try to distract the client away from the hallucinations and involve him in interpersonal activities and actual situations.  | This is to bring the client back to reality.   |

**Table 7.3:** Nursing interventions for withdrawn behaviour

| <i>Interventions</i>  | <i>Rationale</i>  |
|---|---|
| (a) Convey an accepting attitude by making brief, frequent contacts. Show unconditional positive regard.  | This increases feelings of self-worth and facilitates trust.                                  |
| (b) Offer to be with the client during group activities that he finds frightening or difficult. Involve the client gradually in different activities on the unit. | The presence of a trusted individual provides emotional security for the client.              |
| (C) Give recognition and positive reinforcement for the client's voluntary interaction with others.   | Positive reinforcement enhances self-esteem and encourages repetition of acceptable behavior. |

### Nursing Diagnosis IV

Potential for violence, self-directed or directed at others, related to extreme suspiciousness, panic anxiety, catatonic excitement, rage reactions, command hallucinations, evidenced by physical violence, destruction of objects in the environment, self-destructive behavior or active aggressive suicidal acts.

*Objective:* Patient will not harm self or others.

*Intervention:* See Table 7.4.

### Nursing Diagnosis V

Impaired verbal communication related to panic anxiety, disordered, unrealistic thinking, evidenced by loosening of associations, echolalia, verbalizations that reflect concrete thinking, and poor eye contact.

*Objective:* Patient will be able to communicate appropriately and comprehensibly by the time of discharge.

*Intervention:* See Table 7.5.

**Table 7.4:** Nursing interventions for violent behaviour

| <i>Interventions</i>   | <i>Rationale</i>  |
|--|---|
| (a) Maintain low level of stimuli in the client's environment (low lighting, low noise, few people, simple decoration, etc.) | Anxiety level rises in a stimulating environment and may trigger off aggression.  |
| (b) Observe client's behavior frequently.<br><br>Do this while carrying out routine activities.                              | Close observation is necessary so that intervention can occur if required, to ensure client's and others' safety.<br><br>To avoid creating suspicion in the individual. |
| (c) Remove all dangerous objects from the client's environment.  | To prevent the client from using them to harm self or others in an agitated, confused state.  |
| (d) Redirect violent behavior with physical outlets for the anxiety.   | Physical exercise is a safe and effective way of relieving pent-up tension.   |
| (e) Staff should maintain a calm attitude towards the client.  | Anxiety is contagious and can be transmitted from staff to client.  |
| (f) Have sufficient staff available to indicate a show of strength to the client if it becomes necessary.                    | This shows the client evidence of control over the situation and provides some physical security for the staff.   |
| (g) Administer tranquilizers as prescribed. Use of mechanical restraints may become necessary in some cases.                 | If the client is not calmed by "talking down" or the use of medications, restraints may have to be used as a last resort.   |

**Table 7.5:** Nursing interventions for impaired verbal communication

| <i>Interventions</i>  | <i>Rationale</i>   |
|---|--|
| (a) Attempt to decode incomprehensible communication pattern. Seek validation and clarification by stating "Is it what you mean...?" or "I don't understand what you mean by that. Would you please clarify it for me?"   | These techniques reveal how the patient is being perceived by others, while the responsibility for not understanding is accepted by the nurse. |
| (b) Facilitate trust and understanding by maintaining staff assignments as consistently as possible.<br><br>The techniques of VERBALIZING THE IMPLIED is used with the client who is mute (either unable or unwilling to speak).<br><br>For example, "That must have been a very difficult time for you when your mother left. You must have felt all alone." | This approach conveys empathy and encourages the client to disclose painful issues.  |
| (c) Anticipate and fulfill client's needs until functional communication pattern returns.   | Self-care ability may be impaired in some patients who may need assistance initially.  |



### Nursing Diagnosis VI

Self-care deficit related to withdrawal, panic anxiety, perceptual or cognitive impairment, evidenced by difficulty in carrying out tasks associated with hygiene, dressing, grooming, eating and toileting.

**Objective:** Patient will demonstrate ability to meet self-care needs independently.

**Intervention:** See Table 7.6.

### Nursing Diagnosis VII

Ineffective family coping related to highly ambivalent family relationships, impaired family communication, evidenced by neglectful care of the client, extreme denial or prolonged over-concern regarding his illness.

**Objective:** Family will identify more adaptive coping strategies for dealing with patient's illness and treatment regimen.

**Intervention:** See Table 7.7.

**Table 7.6:** Nursing interventions to improve self-care activities

| <i>Interventions</i>   | <i>Rationale</i>   |
|--|--|
| <ul style="list-style-type: none"> <li>(a) Provide assistance with self-care needs as required. Some patients who are severely withdrawn may require total care.</li> <li>(b) Encourage client to perform independently as many activities as possible. Provide positive reinforcement for independent accomplishments.</li> <li>(c) Creative approaches may need to be used with the client who is not eating because he is suspicious of being poisoned (e.g., allow client to open own canned or packaged foods, etc.) If elimination needs are not being met, establish structured schedule to help the client fulfill these needs until he is able to do so independently.</li> </ul> | <p>Patient safety and comfort are nursing priorities.</p> <p>Independent accomplishment and reinforcement enhance self-esteem and promote repetition of desirable behavior.</p> <p>To ensure that self-care needs are met.</p> |

**Table 7.7:** Nursing interventions to improve family coping skills

| <i>Interventions</i>  | <i>Rationale</i>   |
|---|--|
| <ul style="list-style-type: none"> <li>(a) Identify role of the client in the family and how it is affected by his illness. Identify the level of family functioning. Assess communication patterns, interpersonal relationships between the members, problem solving skills and availability of support systems.</li> <li>(b) Provide information to the family about the client's illness, the treatment regimen, long-term prognosis.</li> <li>(c) Practice with family members, how to respond to bizarre behavior and communication patterns and when the client becomes violent.</li> </ul> | <p>These factors will help to identify how successful the family is in dealing with stressful situations and areas where assistance is required.</p> <p>Knowledge and understanding about what to expect may facilitate the family's ability to successfully integrate the schizophrenic patient into the system.</p> <p>A plan of action will assist the family to respond adaptively in the face of what they may consider to be a crisis situation.</p> |

### Evaluation

A few questions that may facilitate the process of evaluation can be:

- Has the patient established trust with at least one staff member?
- Is delusional thinking still prevalent?
- Are hallucinations still evident?
- Is the patient able to interact with others appropriately?
- Is the patient able to carry out all activities of daily living independently?

### NURSING MANAGEMENT FOR A PATIENT WHO EXHIBITS WITHDRAWN BEHAVIOR

The term withdrawn behavior is used to describe a client's retreat from relating to the external world. Withdrawn behavior can occur in conjunction with a number of mental health problems, including schizophrenia, mood disorders and suicidal behavior.

### Characteristics of Withdrawn Behavior Pattern

- Withdrawn behavior pattern may present the picture of a lonely individual who does not respond to the environment. He may walk up and down talking to himself, or may stand or sit in the corner assuming unusual and most uncomfortable positions.
- He has difficulty in expressing his feelings, so he may present the picture of a totally apathetic person, or he may express them in inappropriate ways.
- Ambivalence is another characteristic that might be seen in a withdrawn patient. For example, he may love and hate a person at the same time.
- Disordered thought process is another feature in this patient. The outward expression of this disorganization can be a meaningless jumble of words/sentences, or making up of new words. The patient may also experience sudden thought block. As he creates his own world, the world becomes filled with his own projected ideas and thoughts.

- Regression is another process predominant in a withdrawn patient. When it becomes severe, physical needs like sleep, rest, nutrition and hygiene may be interfered with.

### Interventions

- In taking care of a withdrawn patient, the nurse might be faced with many problems. Communication and interpersonal relationships are the biggest difficulties because the withdrawn patient tends to use symbolized language, or may prefer to rely on non-verbal behavior completely. Establishing initial contact using calm, non-threatening and consistent approaches is important. It necessitates a lot of hard work and patience from the nurse as the patient needs a long period of testing out before he finally trusts her.
- Dealing with hallucinations and delusions may be a problem as this happens in accordance with his own self-created world. Anybody who is trying to destroy that comfortable world may be seen by the patient as a threat to him and to his security. Disintegration in thinking is what makes the withdrawn patient the worst of the mentally ill. As this process can go on for a long time before it is noticed by others, it is often very late when it is identified. This makes it more difficult for the nurse in her efforts to bring the patient back to reality. A lot of tact and expert skill is important, and opportunities should be created for the client to recognize the nurse as a safe contact with present reality and to begin to respond.
- Regression in the patient causes a difficult practical problem, as the patient has to be considered and taken care of as a child. At the same time he has to be treated as an adult, fostering his adult characteristics. Providing sensory stimulation, meeting the client's physiologic and hygienic needs, and promoting the client's physical activity and interactions with others are important interventions.

- Certain general principles in working with these patients are: avoid change of staff, reduce the number of staff who works with them, and be available when the patient really needs the nurse. He may perceive the unavailability of the nurse as another disappointment in his relationship with people in general.
- A one-to-one relationship with the patient is considered most beneficial and least anxiety-producing to the patient. It is necessary to encourage reality contact whenever possible and to discourage him from living in the unreal world. This may be achieved by providing opportunities for interaction with the real environment.
- Give the client positive feedback for any response to your attempted interaction or to the external environment. Gradually increase the amount of time the client spends with others and the number of people with whom the client interacts.
- Active friendliness: As the patient is withdrawn and does not approach anybody, the approach has to be made from the nurse's side and many attempts will have to be made to initiate any conversation or communication.
- Kind firmness: This is another attitude that is to be considered essential. The nurse assumes firmness in expecting the patient to behave in certain ways but should expect the behavior in a kind manner without being authoritative and demanding, showing kindness and understanding while listening to the patient, and helping him handle any difficult situations.

### MOOD DISORDERS

Mood disorders are characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome, which is not due to any other physical or mental disorder.

The prevalence rate of mood disorders is 1.5 percent, and it is uniform throughout the world.

### Classification of Mood Disorders

According to ICD10 (F3) mood disorders are classified as follows:

- Manic episode
- Depressive episode
- Bipolar mood (affective) disorders
- Recurrent depressive disorder
- Persistent mood disorder (including cyclothymia and dysthymia)
- Other mood disorders

### Etiology

The etiology of mood disorders is currently unknown. However, several theories have been propounded which include:

#### *Biological Theories*

*Genetic hypothesis* Genetic factors are very important in predisposing an individual to mood disorders. The lifetime risk for the first-degree relatives of patients with bipolar mood disorder is 25% and of normal controls is 7%. The lifetime risk for the children of one parent with mood disorder is 27% and of both parents with mood disorder is 74%. The concordance rate for monozygotic twins is 65% and for dizygotic twins is 15%.

*Biochemical theories* A deficiency of norepinephrine and serotonin has been found in depressed patients and they are elevated in mania. Dopamine, GABA and acetylcholine are also presumably involved.

#### *Psychosocial Theories*

*Psychoanalytic theory* According to Freud (1957) depression results due to loss of a "loved object", and fixation in the oral sadistic phase of development. In this model, mania is viewed as a denial of depression.

*Behavioral theory* This theory of depression connects depressive phenomena to the experience of uncontrollable events. According to this model, depression is conditioned by repeated losses in the past.

*Cognitive theory* According to this theory depression is due to negative cognitions which includes:

Negative expectations of the environment

Negative expectations of the self

Negative expectations of the future

These cognitive distortions arise out of a defect in cognitive development and cause the individual to feel inadequate, worthless and rejected by others.

*Sociological theory* Stressful life events, e.g. death, marriage, financial loss before the onset of the disease or a relapse probably have a formative effect.

### Manic Episode

Mania refers to a syndrome in which the central features are over-activity, mood change (which may be towards elation or irritability) and self-important ideas.

The lifetime risk of manic episode is about 0.8-1%. This disorder occurs in episodes lasting usually 3 to 4 months, followed by complete recovery.

### Classification of Mania (ICD10)

- Hypomania
- Mania without psychotic symptoms
- Mania with psychotic symptoms
- Manic episode unspecified

### Clinical Features

An acute manic episode is characterized by the following features which should last for at least one week:

#### *Elevated, Expansive or Irritable Mood*

Elevated mood in mania has four stages depending on the severity of manic episodes:

- Euphoria (Stage I): Increased sense of psychological well-being and happiness not in keeping with ongoing events.
- Elation (Stage II): Moderate elevation of mood with increased psychomotor activity.
- Exaltation (Stage III): Intense elevation of mood with delusions of grandeur.

- Ecstasy (Stage IV): Severe elevation of mood, intense sense of rapture or blissfulness seen in delirious or stuporous mania.

Expansive mood is unceasing and unselective enthusiasm for interacting with people and surrounding environment.

Sometimes irritable mood may be predominant, especially when the person is stopped from doing what he wants.

There may be rapid, short-lasting shifts from euphoria to depression or anger.

### Psychomotor Activity

There is an increased psychomotor activity ranging from over activeness and restlessness to manic excitement. The person involves in ceaseless activity. These activities are goal-oriented and based on external environment cues.

### Speech and Thought

- Flight of ideas: Thoughts racing in mind, rapid shifts from one topic to another
- Pressure of speech: Speech is forceful, strong and difficult to interrupt. Uses playful language with punning, rhyming, joking and teasing and speaks loudly
- Delusions of grandeur
- Delusions of persecution
- Distractibility

### Other Features

- Increased sociabilities
- Impulsive behavior
- Disinhibition
- Hypersexual and promiscuous behavior
- Poor judgment
- High-risk activities (buying sprees, reckless driving, foolish business investments, distributing money or articles to unknown persons)
- Dressed up in gaudy and flamboyant clothes although in severe mania there may be poor self-care
- Decreased need for sleep (< 3 hrs)
- Decreased food intake due to over-activity
- Decreased attention and concentration
- Poor judgment
- Absent insight

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### Symptoms of Hypomania

Hypomania is a lesser degree of mania. There is a persistent mild elevation of mood and increased sense of psychological well being and happiness not in keeping with ongoing events. In some cases irritability, conceit, and boorish behavior may take the place of the more usual euphoric sociability.

Concentration and attention may be impaired, thus diminishing the ability to settle down to work or to relaxation and leisure, but this may not prevent the appearance of interests in quite new ventures and activities. In fact, the ability to function becomes better in hypomania, and there's a marked increase in productivity and creativity; many artists and writers have contributed significantly during such periods.

The features of hypomania may be specified as follows:

1. A distinct period of persistently elevated, expansive, or irritable mood, lasting throughout 4 days, that is clearly different from the usual non-depressed mood.
2. During the period of mood disturbance, three (or more) of the following symptoms are persistent (four, if the mood is only irritable) and present to a significant degree:
  - a) inflated self-esteem or grandiosity
  - b) decreased need for sleep (e.g. feels rested after only 3 hours of sleep)
  - c) more talkative than usual
  - d) flight of ideas or subjective experience that thoughts are racing
  - e) distractibility (i.e. attention too easily drawn to unimportant or irrelevant external stimuli)
  - f) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
  - g) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g. the person engages in unrestrained buying sprees, foolish business investments or sexual indiscretions)
3. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.

4. The disturbance in mood and the change in functioning are observable by others.
5. The episode is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalization, and there are no psychotic features.

### Treatment

#### Pharmacotherapy

- Lithium: 900–2100 mg/day.
- Carbamazepine: 600–1800 mg/day.
- Sodium valproate: 600–2600 mg/day.
- Other drugs: Clonazepam, calcium channel blockers, etc.  
(refer chapter 14 for more details on these drugs)

#### Electroconvulsive Therapy (ECT)

ECT can also be used for acute manic excitement if not adequately responding to antipsychotics and lithium.

#### Psychosocial Treatment

Family and marital therapy is used to decrease intrafamilial and interpersonal difficulties and to reduce or modify stressors. The main purpose is to ensure continuity of treatment and adequate drug compliance.

### Nursing Management for Mania

#### Nursing Assessment

Nursing assessment of the manic patient should include assessing the severity of the disorder, forming an opinion about the causes, assessing the patient's resources and judging the effects of patient's behavior on other people. As far as possible all relevant data should be collected from the patient as well as from his relatives, because the patient may not always recognize the extent of his abnormal behavior.

#### Nursing Diagnosis I

High risk for injury related to extreme hyperactivity and impulsive behavior, evidenced by lack of control over purposeless and potentially injurious movements.

*Objective:* Patient will not injure self.

*Intervention:* See Table 7.8.

#### Nursing Diagnosis II

High risk for violence; self-directed or directed at others related to manic excitement, delusional thinking and hallucinations.

*Objective:* Patient will not harm self or others.

*Intervention:* See Table 7.9.

The following are some guidelines for self-protection when handling an aggressive patient:

- Never see a potentially violent person alone.
- Keep a comfortable distance away from the patient (arm length).
- Be prepared to move, violent patient can strike out suddenly.
- Maintain a clear exit route for both the staff and patient.
- Be sure that the patient has no weapons in his possession before approaching him.
- If patient is having a weapon ask him to keep it on a table or floor rather than fighting with him to take it away.
- Keep something like a pillow, mattress or blanket wrapped around arm between you and the weapon.
- Distract the patient momentarily to remove the

weapon (throwing water in the patient's face, yelling, etc.).

- Give prescribed antipsychotic medications

#### Nursing Diagnosis III

Altered nutrition, less than body requirements related to refusal or inability to sit still long enough to eat, evidenced by weight loss, amenorrhea.

*Objective:* Patient will not exhibit signs and symptoms of malnutrition.

*Intervention:* See Table 7.10.

#### Nursing Diagnosis IV

Impaired social interaction related to egocentric and narcissistic behavior, evidenced by inability to develop satisfying relationships and manipulation of others for own desires.

*Objective:* Patient will interact with others in an appropriate manner.

*Intervention:* See Table 7.11.

#### Nursing Diagnosis V

Self-esteem disturbance related to unmet dependency needs, lack of positive feedback, unrealistic self-expectations.

*Objective:* Patient will have realistic expectations about self.

*Intervention:* See Table 7.12.

**Table 7.8:** Nursing interventions for hyperactive behaviour

| <i>Interventions</i>   | <i>Rationale</i>  |
|--|---|
| (a) Keep environmental stimuli to a minimum; assign single room; limit interactions with others; keep lighting and noise level low. Keep his room and immediate environment minimally furnished. | Patient is extremely distractible and responds to even the slightest stimuli. |
| (b) Remove hazardous objects and substances, caution the patient when there is possibility of an accident.   | Rationality is impaired and patient may harm self inadvertently.              |
| (c) Assist patient to engage in activities, such as writing, drawing and other physical exercise.  | To bring relief from pent-up tension and dissipate energy.                    |
| (d) Stay with patient as hyperactivity increases.  | To offer support and provide feeling of security.                             |
| (e) Administer medication as prescribed by physician.  | For providing rapid relief from symptoms of hyperactivity.                    |

**Table 7.9:** Nursing interventions for manic violent behaviour

| <i>Interventions</i>   | <i>Rationale</i>  |
|--|---|
| (a) Maintain low level of stimuli in patient's environment, provide unchallenging environment.   | To minimize anxiety and suspiciousness.   |
| (b) Observe patient's behavior at least every 15 minutes.  | Early intervention must be taken to ensure patient's and others' safety.              |
| (c) Ensure that all sharp objects, glass or mirror items, belts, ties, matchboxes have been removed from patient's environment.                                    | These may be used to harm self or others.   |
| (d) Redirect violent behavior with physical outlet.  | For relieving pent-up tension and hostility.  |
| (e) Encourage verbal expression of feelings.   | -do-  |
| (f) Engage him in some physical exercises like aerobics  | -do-  |
| (g) Maintain and convey a calm attitude to the patient. Respond matter-of-factly to verbal hostility. Talk to him in low, calm voice, use clear and direct speech. | Anxiety is contagious and can be transmitted from staff to patient.                   |
| (h) Have sufficient staff to indicate a show of strength to patient if necessary. State limitations and expectations.  | This conveys control over the situation and provides physical security for the staff. |
| (i) Administer tranquilizing medication; if patient refuses, use of restraints may be necessary. In such a case, explain the reason to the patient.                | Explaining why the restriction is imposed may ensure some control over his behavior.  |
| (j) Following application of restraints observe patient every 15 minutes.  | To ensure that needs for nutrition, hydration and elimination are met                 |
| (k) Remove restraints gradually once at a time   | To minimize potential for injury to patient and staff.                                |

**Table 7.10:** Nursing interventions to improve nutritional status of manic patient

| <i>Interventions</i>  | <i>Rationale</i>  |
|---|---|
| (a) Provide high-protein, high caloric, nutritious finger foods and drinks that can be consumed 'on the run.' | Patient has difficulty sitting still long enough to eat a meal.   |
| (b) Find out patient's likes and dislikes and provide favorite foods.   | To encourage the patient to eat.  |
| (c) Provide 6 – 8 glasses of fluids per day. Have juice and snacks on unit at all times.                      | Intake of nutrients is required on regular basis to compensate for increased caloric requirements due to hyperactivity. |
| (d) Maintain accurate record of intake, output and calorie count. Weigh the patient regularly.                | These are useful data to assess patient's nutritional status.   |
| (e) Supplement diet with vitamins and minerals.   | To improve nutritional status.  |
| (f) Walk or sit with patient while he eats.   | To offer support and to encourage patient to eat.   |

Table 7.11: Nursing interventions for manipulative behaviour

| Interventions   | Rationale  |
|---|--|
| (a) Recognize that manipulative behavior helps to decrease feelings of insecurity by increasing feelings of power and control.  | Understanding the rationale behind the behavior may facilitate greater acceptance of the individual.       |
| (b) Set limits on manipulative behavior. Explain the consequences if limits are violated. Terms of the limits must be agreed upon by all the staff who will be working with the patient | Consequences for violation of limits must be consistently administered.                                    |
| (c) Ignore attempts by patient to argue or bargain his way out of the limit setting.  | Lack of feedback may decrease these behaviors.   |
| (d) Give positive reinforcement for non-manipulative behaviors.   | To enhance self-esteem and promote repetition of desirable behavior.                                       |
| (e) Discuss consequences of patient's behavior and how attempts are made to attribute them to others.   | Patient must accept responsibility for own behavior before adaptive change can occur.                      |
| (f) Help patient identify positive aspects about self, recognize accomplishments and feel good about them.  | As self-esteem increases patient will experience a lesser need to manipulate others for own gratification. |

Table 7.12: Nursing interventions to improve self-esteem among manic patient

| Interventions  | Rationale   |
|--|---|
| (a) Ask how client would like to be addressed. Avoid approaches that imply different perception of the client's importance.  | Grandiosity is thought actually to reflect low self-esteem.   |
| (b) Explain rationale for requests by staff unit routine etc; strictly adhere to courteous approaches, matter-of-fact style and friendly attitudes.                      | Nursing approaches should reinforce patient's dignity and worth; understanding reasons enhances co-operation with regimen. Problem solving begins with agreeing on the problem. |
| (c) Encourage verbalization and identification of feelings related to issues of chronicity, lack of control over self, etc.  | Unrealistic goals will increase failures and lower self-esteem even more.   |
| (d) Offer matter-of-fact feedback regarding unrealistic plans. Help him to set realistic goals for himself.  | Role rehearsal is helpful in returning patient to the level of independent functioning. When the individual is functioning well, sense of self-esteem is enhanced.              |
| (e) Encourage client to view life after discharge and identify aspects over which control is possible. Through role play, practice how he will demonstrate that control. |   |

#### Nursing Diagnosis VI

Altered family processes related to euphoric mood and grandiose ideas, manipulative behavior, refusal to accept responsibility for

own actions.

*Objective:* The family members will demonstrate coping ability in dealing with the patient.

*Intervention:* See Table 7.13.

**Table 7.13:** Nursing interventions to improve family coping skills

| <i>Interventions</i>  | <i>Rationale</i>   |
|---|--|
| (a) Determine individual situation and feelings of individual family members like guilt, anger, powerlessness, despair and alienation.                    | Living with a family member having bipolar illness fosters a multitude of feelings and problems that can affect interpersonal relationships and may result in dysfunctional responses and family disintegration. |
| (b) Assess patterns of communication. For example: Are feelings expressed freely? who makes decisions? What is the interaction between family members?    | Provides clues to the degree of problem being experienced by individual family members and coping skills used to handle the crisis.  |
| (c) Determine patterns of behavior displayed by patient in his relationships with others, e.g. manipulation of self-esteem of others, limit testing, etc. | These behaviors are typically used by the manic individual to manipulate others. The result is alienation, guilt, ambivalence and high rates of divorce.   |
| (d) Assess the role of patient in the family, like provider etc, and how the illness affects the roles of other members.                                  | When the role of an ill person is not filled family disintegration can occur.  |
| (e) Provide information about behavior patterns and expected course of the illness.   | Assists family to understand the various aspects of bipolar illness. This may relieve guilt and promote family discussions of the problems and solutions.  |

### **Evaluation**

In this step, the nurse assesses if the goals of care are achieved. The plan may need to be revised or modified in the light of this evaluation.

### **Nursing Management for Hypomania**

#### *Assessment*

Assessment includes judging the severity of the symptoms, forming an opinion about the causes, assessing the patient's social resources, and gauging the effect of the disorder on other people.

- In assessing the severity of symptoms, the patient's capacity to work or engage in family life and social activities should be noted. This is important to prevent the patient from causing himself long-term difficulties due to ill-judged decisions and unjustified extravagance.
- Usually the causes may be endogenous, but it is important to identify any life events that may have provoked the onset. Sometimes the episode may follow physical illness, treatment by drugs (especially steroids), or surgical operations.

- The patient's resources and effect on other people should be assessed. The patient's responsibilities in the care of dependent children or at work should be considered carefully.

#### *Interventions*

#### **NURSING DIAGNOSIS I**

Risk of injury related to inability to perceive potentially harmful situations evidenced by impulsive behavior.

*Objective:* To reduce risky behavior and avert injury.

*Intervention:* See Table 7.14.

#### **NURSING DIAGNOSIS II**

Impaired social interaction related to short attention span, high level of distractibility and labile mood, evidenced by insufficient or excessive quantity or ineffective quality of social exchange.

*Objective:* Patient will demonstrate acceptable interaction with others.

*Intervention:* See Table 7.15.

**Table 7.14:** Nursing interventions to reduce risky behaviour and avert injury among hypomanic patients

| <i>Interventions</i>   | <i>Rationale</i>  |
|--|---|
| <ul style="list-style-type: none"> <li>• Talk with the client about safe and unsafe behavior.</li> <li>• Assess the frequency and severity of accidents.</li> <li>• Provide supervision for potentially dangerous situations. Limit the client's participation in activities when safety cannot be ensured.</li> <li>• State expectations for behavior in clear terms.</li> <br/> <li>• Make correct feedback as specific as possible. For example, "Do not jump down the stairs. Walk down one step at a time."</li> <li>• Set limits that are directly related to the undesirable behavior. Institute them as soon as possible after the occurrence of the behavior. Continuous supervision is needed to prevent the patient from developing full-blown manic symptoms.</li> </ul> | <p>This provides the client with clear expectations.</p> <p>It is necessary for baseline data.</p> <p>This is necessary, because the client's ability to perceive harmful consequences of a behavior is impaired.</p> <p>The client may be unable to process social cues to guide reasonable behavior choices.</p> <p>Specific feedback will help the client understand expectations.</p> <p>The client will be better able to draw the correlation between undesirable behavior and consequences if the two are related to each other.</p> |

**Table 7.15:** Nursing interventions to improve social interaction among hypomanic patients

| <i>Interventions</i>  | <i>Rationale</i>   |
|---|--|
| <ul style="list-style-type: none"> <li>• Identify the factors that aggravate and alleviate the client's performance.</li> <li>• Provide an environment as free from distractions as possible. Gradually increase the amount of environmental stimuli.</li> <li>• Give instructions slowly, using simple language and concrete directions.</li> <li>• Provide positive feedback for completion of each step of desirable activity/behavior.</li> <li>• Protect other clients from being drawn into the client's influence, especially those who might be non-assertive or vulnerable.</li> </ul> | <p>External stimuli that exacerbate the client's problems can be identified and minimized.</p> <p>The client's ability to deal with external stimulation is impaired.</p><br><p>The client's ability to comprehend complex instructions is reduced.</p> <p>Positive feedback increases the likelihood of desirable behavior.</p> <p>Clients with hypomania have manipulative behavior.</p> |

#### **NURSING DIAGNOSIS III**

Ineffective coping skills related to poor impulse control evidenced by acting out behavior.

*Objective:* Patient will not harm self or others.

*Intervention:* See Table 7.16.

#### **NURSING DIAGNOSIS IV**

Disturbed thought process related to disorientation and decreased concentration evidenced by disruption in activities.

*Objective:* Patient will demonstrate adequate cognitive function.

*Intervention:* See Table 7.17.

#### **EVALUATION**

In this step the nurse assesses if the goals of care are achieved. The plan may need to be revised or modified in the light of this evaluation.

#### **Depressive Episode**

Depression is a widespread mental health problem affecting many people. The lifetime risk of

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**Table 7.16:** Nursing interventions to increase self-control among hypomanic patients

| Interventions   | Rationale   |
|---|---|
| <ul style="list-style-type: none"> <li>State rules, expectations and responsibilities clearly to the client, including consequences for exceeding limits.</li> <li>Use time out when the client begins to lose behavioral control.</li> <li>Encourage the client to verbalize his feelings.</li> <li>Teach the client a simple problem solving process : describe the problem, list alternatives, evaluate choices, and select and implement an alternative.</li> </ul> | <p>Clear expectations give the client limits to which his behavior must conform, and what to expect if he exceeds those limits.</p> <p>Time out period is not a punishment but an opportunity for the client to regain control.</p> <p>It is an initial step towards resolving difficulties.</p> <p>The client's ability to think, judge or solve problems is impaired.</p> |

**Table 7.17:** Nursing interventions to improve cognitive function in hypomanic patients

| Interventions   | Rationale  |
|---|--|
| <ul style="list-style-type: none"> <li>Use a firm yet calm, relaxed approach.</li> <li>Set and maintain limits on behavior that is destructive or adversely affects others.</li> <li>Decrease environmental stimuli whenever possible. Respond to cues of increased restlessness or agitation by removing stimuli and perhaps isolating the client, to single or private occupancy room may be beneficial.</li> <li>Provide a consistent structured environment. Let the client know what is expected of him. Set goals with the client as soon as possible.</li> </ul> | <p>The nurse's presence and manner will help to communicate her interest. Limits must be established by others when the client is unable to use internal controls effectively.</p> <p>The client's ability to deal with stimuli is impaired.</p> <p>Consistency and structure can reassure the client and foster desirable behavior.</p> |

depression in males is 8 to 12% and in females it is 20 to 26%. Depression occurs twice as frequently in women as in men.

### Classification of Depression (ICD10)

- Mild depression
- Moderate depression
- Severe depression
- Severe depression with psychotic symptoms

### Clinical Features

A typical depressive episode is characterized by the following features, which should last for at least two weeks in order to make a diagnosis:

**Depressed mood:** Sadness of mood or loss of interest and loss of pleasure in almost all activities (pervasive sadness), present throughout the day (persistent sadness).

**Depressive cognitions:** Hopelessness (a feeling of 'no hope in future' due to pessimism), helplessness (the patient feels that no help is possible), worthlessness (a feeling of inadequacy and inferiority), unreasonable guilt and self-blame over trivial matters in the past.

**Suicidal thoughts:** Ideas of hopelessness are often accompanied by the thought that life is no longer worth living and that death had come as a welcome release. These gloomy preoccupations may progress to thoughts of and plans for suicide.

**Psychomotor activity:** Psychomotor retardation is frequent. The retarded patient thinks, walks and acts slowly. Slowing of thought is reflected in the patient's speech; questions are often answered after a long delay and in a monotonous voice. In older patients agitation is common with marked anxiety, restlessness and feelings of uneasiness.

**Psychotic features:** Some patients have delusions and hallucinations (the disorder may then be termed as psychotic depression); these are often mood congruent, i.e. they are related to depressive themes and reflect the patient's dysphoric mood. For example, nihilistic delusions (beliefs about the non-existence of some person or thing), delusions of guilt, delusions of poverty, etc. may be present.

Some patients experience delusions and hallucinations that are not clearly related to depressive themes (mood incongruent), for example, delusion of control. The prognosis then appears to be much worse.

**Somatic symptoms of depression,** according to ICD10 (these are called as '*melancholic features*' in DSMIV):

- Significant decrease in appetite or weight.
- Early morning awakening, at least 2 or more hours before the usual time of waking up.
- Diurnal variation, with depression being worst in the morning.
- Pervasive lack of interest and lack of reactivity to pleasurable stimuli.
- Psychomotor agitation or retardation.

### Other Features

- Difficulties in thinking and concentration.
- Subjective poor memory.
- Menstrual or sexual disturbances.
- Vague physical symptoms such as fatigue, aching discomfort, constipation, etc.

### Treatment

#### Pharmacotherapy

Antidepressants are the treatment of choice for a vast majority of depressive episodes (See Chapter 14, pg 175).

#### Electroconvulsive therapy (ECT)

Severe depression with suicidal risk is the most important indication for ECT (See Chapter 14, pg 182.).

#### Psychosocial Treatment

- *Cognitive therapy:* It aims at correcting the depressive negative cognitions like hopelessness, worthlessness, helplessness and pessimistic ideas, and replacing them with new cognitive and behavioral responses.
- *Supportive psychotherapy:* Various techniques are employed to support the patient. They are reassurance, ventilation, occupational therapy, relaxation and other activity therapies.
- *Group therapy:* Group therapy is useful for mild cases of depression. In group therapy negative feelings such as anxiety anger, guilt, despair are recognized and emotional growth is improved through expression of their feelings.
- *Family therapy:* Family therapy is used to decrease intrafamilial and interpersonal difficulties and to reduce or modify stressors, which may help in faster and more complete recovery.
- *Behavior therapy:* It includes social skills training, problem solving techniques, assertiveness training, self-control therapy, activity scheduling and decision making techniques.

### Course and Prognosis of Mood Disorders

An average manic episode lasts for 3-4 months, while a depressive episode lasts for 4-9 months.

#### Good Prognostic Factors

- Abrupt or acute onset
- Severe depression
- Typical clinical features
- Well-adjusted premorbid personality
- Good response to treatment

#### Poor Prognostic Factors

- Double depression
- Co-morbid physical disease, personality disorders or alcohol dependence

- Chronic ongoing stress
- Poor drug compliance
- Marked hypochondriacal features or mood-incongruent psychotic features

## OTHER MOOD DISORDERS

### Bipolar Mood Disorder

This is characterized by recurrent episodes of mania and depression in the same patient at different times.

Bipolar mood disorder is further classified into bipolar I and bipolar II disorder (DSMIV).

Bipolar I: Episodes of severe mania and severe depression.

Bipolar II: Episodes of hypomania and severe depression.

### Recurrent Depressive Disorder

This disorder is characterized by recurrent depressive episodes. The current episode is specified as mild, moderate, severe, severe with psychotic symptoms.

### Persistent Mood Disorder

#### (Cyclothymia and Dysthymia)

These disorders are characterized by persistent mood symptoms that last for more than 2 years.

Cyclothymia refers to a persistent instability in mood in which there are numerous periods of mild elation or mild depression.

Dysthymia (neurotic/reactive depression) is a chronic, mild depressive state persisting for months or years. It is more common in females with an average age of onset in late third decade. An episode of major depression may sometimes become superimposed on an underlying neurotic depression. This is known as 'double depression.'

(see Table 7.18 for differences between somatic and neurotic depression).

## Nursing Management of Major Depressive Episode

### Nursing Assessment

Nursing assessment should focus on judging the severity of the disorder including the risk of suicide, identifying the possible causes, the social resources available to the patient, and the effects of the disorder on other people. Although there is a risk of suicide in every depressed patient, the risk is much more in the presence of the following factors:

- Presence of marked helplessness
- Male sex
- More than 40 years of age

**Table 7.18:** Differences between somatic (major/endogenous depression/ melancholia) and neurotic depression (reactive)

|     | <i>Endogenous</i>   | <i>Reactive</i>  |
|-----|---|--|
| (a) | Caused by factors within the individual.  | Caused by stressful events.                                    |
| (b) | Premorbid personality: cyclothymic or dysthymic.  | Premorbid personality: anxious, or obsessive.                  |
| (c) | Early morning awakening (late insomnia).  | Difficulty in falling asleep (early insomnia).                 |
| (d) | Patient feels more sad in the morning.  | Patient feels more sad in the evening.                         |
| (e) | Feels better when alone.  | Feels better when in a group.                                  |
| (f) | Psychotic features like psychomotor retardation, suicidal tendencies, delusions etc are common. | Usually psychomotor agitation and no other psychotic features. |
| (g) | Relapses are common.  | Relapses are uncommon.   |
| (h) | ECT and antidepressants are used for management.  | Psychotherapy and antidepressants are used for management.     |
| (i) | Insight is absent.  | Insight is present.  |

- Unmarried, widowed or divorced
- Written or verbal communication of suicidal intent or plan
- Early stages of depression
- Recovery from depression(at the peak of depression the patient is usually either too depressed or too retarded to commit suicide)
- Period of three months from recovery

The nurse should routinely enquire about the patient's work, finances, family life, social activities, general living conditions and physical health. It is also important to consider whether the patient could endanger other people, particularly if there are depressive delusions and the patient may act on them.

### Nursing Diagnosis I

High risk of self-directed violence related to depressed mood, feelings of worthlessness and anger directed inward on the self.

*Objective:* Patient will not harm self.

*Intervention:* See Table 7.19.

### Nursing Diagnosis II

Dysfunctional grieving related to real or perceived loss, bereavement, evidenced by denial of loss, inappropriate expression of anger, inability to carry out activities of daily living.

*Objective:* Patient will be able to verbalize normal behaviors associated with grieving.

*Intervention:* See Table 7.20.

### Nursing Diagnosis III

Powerlessness related to dysfunctional grieving process, life-style of helplessness, evidenced by feelings of lack of control over life situations, over-dependence on others to fulfil needs.

*Objective:* The patient will be able to take control of life situations.

*Intervention:* See Table 7.21.

### Nursing Diagnosis IV

Self-esteem disturbance related to learned helplessness, impaired cognition, negative view of

self, evidenced by expression of worthlessness, sensitivity to criticism, negative and pessimistic outlook.

*Objective:* Patient will be able to verbalize positive aspects about self and attempt new activities without fear of failure.

*Intervention:* See Table 7.22.

### Nursing Diagnosis V

Altered communication process related to depressive cognitions, evidenced by being unable to interact with others, withdrawn, expressing fear of failure or rejection.

*Objective:* Patient will communicate or interact with staff or other patients in the unit.

*Intervention:* See Table 7.23.

### Nursing Diagnosis VI

Altered sleep and rest, related to depressed mood and depressive cognitions evidenced by difficulty in falling asleep, early morning awakening, verbal complaints of not feeling well-rested.

*Objective:* Patient will sleep adequately during the night.

*Intervention:* See Table 7.24.

### Nursing Diagnosis VII

Altered nutrition, less than body requirements related to depressed mood, lack of appetite or lack of interest in food, evidenced by weight loss, poor muscle tone, pale conjunctiva, poor skin turgor.

*Objective:* Patient's nutritional status will improve.

*Intervention:* See Table 7.25.

### Nursing Diagnosis VIII

Self-care deficit related to depressed mood, feelings of worthlessness, evidenced by poor personal hygiene and grooming.

*Objective:* Patient will maintain adequate personal hygiene.

*Intervention:* See Table 7.26.

**Table 7.19:** Nursing interventions for suicidal behaviour

| <i>Interventions</i>  | <i>Rationale</i>   |
|---|--|
| <p>(a) Ask the patient directly "Have you thought about harming yourself in any way? If so, what do you plan to do? Do you have the means to carry out this plan?"</p> <p>(b) Create a safe environment for the patient. Remove all potentially harmful objects from patient's vicinity (sharp objects, straps, belts, glass items, alcohol, etc.), supervise closely during meals and medication administration.</p> <p>(c) Formulate a short-term verbal or written contract that the patient will not harm self. Secure a promise that the patient will seek out staff when feeling suicidal.</p> <p>(d) It may be desirable to place the client near the nursing station. Do not leave the patient alone. Observe for passive suicide - the patient may starve or fall asleep in the bath-tub or sink.</p> <p>(e) Close observation is especially required when the patient is recovering from the disease.</p> <p>(f) Do not allow the patient to put the bolt on his side of the door of bathroom or toilet.</p> <p>(g) If the patient suddenly becomes unusually happy or gives any other clues of suicide, special observation may be necessary.</p> <p>(h) Encourage the patient to express his feelings, including anger.</p> | <p>The risk of suicide is greatly increased if the patient has developed a plan and if means exist for the patient to execute the plan. Patient's safety is nursing priority.</p> <p>A degree of the responsibility for his safety is given to the patient. Increased feelings of self-worth may be experienced when patient feels accepted unconditionally regardless of behavior. Patient's safety is nursing priority.</p> <p>At the peak of depression the patient is usually too retarded to carry out his suicidal plans. Patient's safety is nursing priority.</p> <p>-do-</p> <p>Depression and suicidal behavior may be viewed as anger turned inward on the self. If the anger can be verbalized in a non-threatening environment, the patient may be able to eventually resolve these feelings.</p> |

**Table 7.20:** Nursing interventions for grief reaction

| <i>Interventions</i>   | <i>Rationale</i>  |
|--|---|
| <p>(a) Assess stage of fixation in grief process.</p> <p>(b) Be accepting of patient and spend time with him. Show empathy, care and unconditional, positive regard.</p> <p>(c) Explore feelings of anger and help patient direct them towards the intended object or person.</p> <p>(d) Provide simple activities which can be easily and quickly accomplished. Gradually increase the amount and complexity of activities.</p> | <p>Accurate baseline data is required to plan accurate care.</p> <p>These interventions provide the basis for a therapeutic relationship.</p> <p>Until patient can recognize and accept personal feelings regarding the loss, grief work cannot progress. Physical activities are safe and an effective way of relieving anger.</p> |

**Table 7.21:** Nursing interventions for over dependence behaviour

| Interventions  | Rationale   |
|--|---|
| (a) Allow the patient to take decisions regarding own care.  | Providing patient with choices will increase his feelings of control.                     |
| (b) Ensure that goals are realistic and that patient is able to identify life situations that are realistically under his control. | To avoid repeated failures which further increase his sense of powerlessness.             |
| (c) Encourage the patient to verbalize feelings about areas that are not in his ability to control.                                | Verbalization of unresolved issues may help the patient to accept what cannot be changed. |

**Table 7.22:** Nursing interventions to improve self-esteem in depressed patients

| Interventions   | Rationale   |
|---|---|
| (a) Be accepting of patient and spend time with him, even though pessimism and negativism may seem objectionable.               | These interventions contribute towards feeling of self-worth. |
| (b) Focus on strengths and accomplishments and minimize failures.   | -do-  |
| (c) Provide him with simple and easily achievable activity. Encourage the patient to perform his activities without assistance. | Success and independence promote feelings of self-worth.      |
| (d) Encourage patient to recognize areas of change and provide assistance toward this effort.                                   | To facilitate problem solving.                                |
| (e) Teach assertiveness and coping skills.  | Their use can serve to enhance self-esteem.                   |

**Table 7.23:** Nursing interventions to improve communication skills in depressed patients

| Interventions   | Rationale   |
|---|---|
| (a) Observe for non-verbal communication. The patient may say that he is happy but looks sad. Point out this discrepancy in what he is saying and actually feeling. | To facilitate better response and communication.                |
| (b) Use short sentences. Ask questions in such a way that the patient will have to answer in more than one word.  | -do-  |
| (c) Use silence appropriately without communicating anxiety or discomfort in doing so.  | Using silence when the situation demands can be therapeutic.    |
| (d) Introduce the patient to another patient who is quiet and possibly convalescing from depression.  | There is less anxiety in relating to a person other than staff. |
| (f) As he improves, take him to other patients and see that he is actually included as part of the group.   | Group support is important in facilitating communication.       |

**Table 7.24:** Nursing interventions to improve sleeping pattern

| <i>Interventions</i>  | <i>Rationale</i>   |
|---|--|
| (a) Plan daytime activities according to the patient's interests, do not allow him to sit idle. | To improve sleep during night.   |
| (b) Ensure a quiet and peaceful environment when the patient is preparing for sleep.            | -do-   |
| (c) Provide comfort measures (back rub, tepid bath, warm milk, etc).                            | -do-   |
| (d) Do not allow the patient to sleep for long time during the day.                             | -do-   |
| (e) Give p.r.n. sedatives as prescribed.  | -do-   |
| (f) Talk to the patient for a brief period at bedtime. Do not enter into lengthy conversations. | Talking to the patient helps to relieve his anxiety, but engaging in long talks may increase depressive thinking . |

**Table 7.25:** Nursing interventions to improve nutritional status in depressive patients

| <i>Interventions</i>  | <i>Rationale</i>  |
|---|---|
| (a) Closely monitor the client's food and fluid intake; maintain intake and output chart.               | These are useful data for assessing nutritional status. |
| (b) Record patient's weight regularly.  | -do-  |
| (c) Find out the likes and dislikes of the person before he was sick and serve the best preferred food. | To encourage eating and improve nutritional status.     |
| (d) Serve small amounts of a light or liquid diet frequently that is nourishing.                        | -do-  |
| (e) Record the client's pattern of bowel elimination.   | To assess for constipation.                             |
| (h) Encourage more fluid intake, roughage diet and green leafy vegetables.                              | For relief of constipation if present.                  |

**Table 7.26:** Nursing interventions to improve self-care for depressed patients

| <i>Interventions</i>  | <i>Rationale</i>   |
|---|--|
| (a) Ensure that he takes his bath regularly.  | Depressive patient will not have any interest for self-care and may need assistance. |
| (b) Do not ask the patient's permission for a wash or bath. For instance, do not ask "Do you want to have a bath?" Instead lead the patient to the action with positive suggestions, e.g. "The water is ready, let me take you for a bath." | Positive suggestions will usually enhance patient's cooperation.                     |
| (c) When the patient has taken care of himself, express realistic appreciation.   | Positive reinforcement will improve desirable behavior.                              |

### Evaluation

Evaluation is facilitated by using the following types of questions:

- Has self-harm to the individual been avoided?
- Have suicidal ideations subsided?
- Does patient set realistic goals for self?
- Is he able to verbalize positive aspects about self, past accomplishments and future prospects?

### REVIEW QUESTIONS

- Types of hallucinations (Feb 2000, Apr 2002)
- Types of delusions (Feb 2000, Oct 2004)
- Mutism (Nov 2003)
- Echolalia (Oct 2000, Apr 2002)
- Echopraxia (Oct 2000)
- Ambivalence, anhedonia, nihilism, confabulation, circumstantiality, tangentiality, clang associations, flight of ideas (Oct 2000), poverty of thought, loosening of association, perseveration, verbigeration, formal thought disorder, thought alienation phenomena, déjà vu, jamais vu.
- Pseudo hallucinations (Oct 2006)
- Pressure of thought (Oct 2000, Oct 2006)
- Disorders of thought (Nov 2003)
- Apathy (Nov 2003)
- Thought block (Apr 2004)
- Neologism (Nov 2003, Apr 2004)
- Discuss the concepts of schizophrenia and identify predisposing factors in the development of schizophrenia (Nov 2003)
- Schizophrenia (Apr 2002, Apr 2004, Oct 2005)
- Dynamics of schizophrenia (Feb 2002)
- Types of schizophrenia (Feb 2000)
- Excited catatonia (Oct 2000)
- Catatonic stupor (Nov 2002)
- Clinical features of catatonic stupor (Oct 2000)
- Nursing management of a patient with paranoid schizophrenia (Oct 2004)
- Withdrawn behavior (Nov 1999)
- Aggressive behavior (Oct 2000, Nov 2003, Oct 2004, Apr 2006)
- Mood disorders (Nov 2002, Nov 2003)
- Clinical features of mania (Oct 2000, Apr 2004)
- Triad of mania (Oct 2004)
- Nursing management of patient with mania (Oct 2000, Nov 2003, Apr 2006)
- Psychomotor retardation (Oct 2004)
- Nursing management of patient with depression (Feb 2001, Oct 2004, Apr 2006)
- Cyclothymia-dysthymia
- Differences between endogenous and reactive depression
- Hypomania
- Endogenous depression (Nov 2003, Apr 2006)

# 8

# Organic Mental Disorders

- CLASSIFICATION OF ORGANIC MENTAL DISORDERS
- DEMENTIA
- DELIRIUM
- ORGANIC AMNESTIC SYNDROME
- MENTAL DISORDERS DUE TO BRAIN DAMAGE, DYSFUNCTION AND PHYSICAL DISEASE
- PERSONALITY AND BEHAVIORAL DISORDERS DUE TO BRAIN DISEASE, DAMAGE AND DYSFUNCTION

Organic mental disorders are behavioral or psychological disorders associated with transient or permanent brain dysfunction. These disorders have a demonstrable and independently diagnosable cerebral disease or disorder. They are classified under Fo in ICD10.

## CLASSIFICATION OF ORGANIC MENTAL DISORDERS

- Dementia
- Delirium
- Organic amnestic syndrome
- Mental disorders due to brain damage, dysfunction and physical disease
- Personality and behavioral disorders due to brain disease, damage and dysfunction

## DEMENTIA (CHRONIC ORGANIC BRAIN SYNDROME)

Dementia is an acquired global impairment of intellect, memory and personality but without impairment of consciousness.

### Incidence

Dementia occurs more commonly in the elderly than in the middle-aged. It increases with age from

0.1 percent in those below 60 years of age to 15 to 20 percent in those who are 80 years of age.

### Etiology

#### *Untreatable and irreversible causes:*

- Degenerating disorders of CNS
  - Alzheimer's disease (this is the most common of all dementing illnesses)
  - Pick's disease
  - Huntington's chorea
  - Parkinson's disease

#### *Treatable and reversible causes:*

- Vascular—multi-infarct dementia
- Intracranial space occupying lesions
- Metabolic disorders—hepatic failure, renal failure
- Endocrine disorders—myxedema, Addison's disease
- Infections—AIDS, meningitis, encephalitis
- Intoxication—alcohol, heavy metals (lead, arsenic), chronic barbiturate poisoning
- Anoxia—anemia, post-anesthesia, chronic respiratory failure
- Vitamin deficiency, especially deficiency of thiamine, and nicotine
- Miscellaneous—heatstroke, epilepsy, electric injury

### Stages of Dementia

#### *Stage I: Early stage (2 to 4 years)*

- Forgetfulness
- Declining interest in environment
- Hesitancy in initiating actions
- Poor performance at work

*Stage II: Middle stage (2 to 12 years)*

- Progressive memory loss
- Hesitates in response to questions
- Has difficulty in following simple instructions
- Irritable, anxious
- Wandering
- Neglects personal hygiene
- Social isolation

*Stage III: Final stage (up to a year).*

- Marked loss of weight because of inadequate intake of food
- Unable to communicate
- Does not recognize family
- Incontinence of urine and feces
- Loses the ability to stand and walk
- Death is usually caused by aspiration pneumonia

*Clinical Features (for Alzheimer's Type)*

- Personality changes: lack of interest in day-to-day activities, easy mental fatigability, self-centered, withdrawn, decreased self-care
- Memory impairment: recent memory is prominently affected
- Cognitive impairment: disorientation, poor judgment, difficulty in abstraction, decreased attention span
- Affective impairment: labile mood, irritability, depression
- Behavioral impairment: stereotyped behavior, alteration in sexual drives and activities, neurotic/psychotic behavior
- Neurological impairment: aphasia, apraxia, agnosia, seizures, headache
- Catastrophic reaction: agitation, attempt to compensate for defects by using strategies to avoid demonstrating failures in intellectual performances, such as changing the subject, cracking jokes or otherwise diverting the interviewer
- Sundowner syndrome: It is characterized by drowsiness, confusion, ataxia; accidental falls may occur at night when external stimuli such as light and interpersonal orienting cues are diminished

*Course and Prognosis*

Insidious onset but slow progressive deterioration occurs.

*Treatment*

Until now no specific medicine is available to treat Alzheimer's disease. A drug called 'Tacrine' is being used in western countries. Tacrine (Tetra hydro amino acridine) is a long-acting inhibitor of acetylcholine and also delays the progression of the illness.

The following drugs may be of some use in causing symptomatic relief:

- benzodiazepines for insomnia and anxiety
- antidepressants for depression
- antipsychotics to alleviate hallucinations and delusions
- anticonvulsants to control seizures

Nursing care for patients of Alzheimer's disease is most important. Whether at home, in an acute hospital environment, a day-care center or in a long-term stay institution. Care givers must be trained to promote the patient's remaining intellectual abilities; help them maintain their independence in attending to their usual functions and avoid injuries; and provide for a good quality of life.

*Nursing Interventions**Daily Routine*

Maintaining a daily routine includes drawing up a fixed timetable for the patient for waking up in the morning, toilet, exercise and meals. This gives the patient a sense of security.

Patients often deteriorate after dark, a phenomenon known as 'sun downing'. Additional care must be taken during the evening and at night. Orient the patient to reality in order to decrease confusion; clock with large faces aid in orientation to time. Use calendar with large writing and a separate page for each day. Provide newspapers which stimulate interest in current events. Orientation of place, person and time should be given before approaching the patient.

### *Nutrition and Body Weight*

Patient should be provided a well-balanced diet, rich in protein, high in fiber, with adequate amount of calories. Allow plenty of time for meals. Tell the patient which meal it is and what is there to eat; food served should be neither too hot nor too cold. Many patients have sugar craving. Care should be taken that such patients do not gain weight. The diet should take into account other medical illnesses which require diet modification, such as diabetes or high blood pressure. Semi-solid diet is the safest while liquids are the most dangerous as these can be easily aspirated into the lungs.

### *Personal Hygiene*

Particular care should be taken about the patient's personal hygiene including brushing of teeth, bathing, keeping the skin clean and dry, particularly in areas prone to perspiration, such as the armpits and groin. Caustic substances such as spirit or antiseptic solutions should not be used routinely on the skin. Remember to check finger and toe nails regularly, cut them if the person cannot do it by himself.

People with dementia may have problem with the lock on the bathroom door; if this happens it is advisable to remove the lock. Compliment the patient when he/she looks good.

### *Toilet Habits and Incontinence*

Toilet habits should be established as soon as possible and maintained as a rigid routine. This includes conditioned behavior such as going for bowel movement immediately after a cup of tea. The patient should be taken to urinate at fixed interval, depending on the season and amount of fluid intake. Prostate trouble common in elderly men leads to discomfort as it causes urgency and frequency of urination particularly in winters. A doctor should check this.

Incontinence is very distressing to the patient and family. Once incontinence sets in, the undergarments, pants of the patient and the house in general start reeking of foul smell. Toilet habits,

established in healthy years must be maintained as long as possible by gently persuading the patient to go to the toilet and use it. When the first sign of incontinence appears doctor should check for an underlying cause if any, such as urinary infection or urinary tract damage.

Constipation is a frequent cause of discomfort to the patient. The quantity of faeces passed each morning should be checked to ensure that the patient is not constipated. Constipation can be avoided by adding fiber supplements and roughage to the diet on a daily basis.

### *Accidents*

Great care should be taken to avoid accidents caused by tripping over furniture, falling down the stairs or slipping in the bathroom. The reasons for falling include loose and poorly fitting footwear and wrinkled carpets. Ideally, patients should be made to wear soft slip-on shoes with straps which fit securely. Any floor covering must be firmly secured.

Older people have been driving for years and in modern cities many people are dependent on their personal cars for transportation. Once early signs of the disease appear, patients should be gently persuaded to stop driving as this can pose a hazard to them and others.

Make sure that lights are bright enough. Keep matches, bleach, and paints out of reach. Do not allow the patient to take medication alone.

### *Fluid Management*

The patients require as much fluid as normal people and this depends on the season. Ideally, sufficient fluid should be given during the day and only the minimum essential amount of fluid (some water with dinner) after 6 pm. The last cup of tea should be given around 5 pm. After that no beverages including tea, coffee, cocoa or any other caffeine containing drinks should be given, as all these promote urination. Proper fluid management will reduce bed-wetting and also reduce the number of times the patient will need to get up during the night.

### *Moods and Emotions*

Some patients of Alzheimer's disease have abrupt change in their moods and emotions. These changes can be unpredictable. Mood changes are best controlled by keeping a calm environment with fixed daily routine. The patients should not be questioned repeatedly or given too many choices, such as what they want to eat or what they want to wear. Mood changes are also amenable to distraction, particularly if topics related to the past are discussed or favorite pieces of music played. For example, if music that reminds the patients of their childhood is played, the pleasant associations put them in a nostalgic mood. If patient behavior and emotions are distressing to the family members the doctor may prescribe some medications to calm the patient.

### *Wandering*

Patients of Alzheimer's disease often lose their geographic orientation and can get lost even in familiar surroundings. They may be found wandering aimlessly either in the neighborhood or far away. It is advisable to have some identification bracelet or card always in their possession. The doors of the house should be securely locked so that the patients cannot leave unnoticed. The patient should always be accompanied while going for walks or for simple chores outside the house.

### *Disturbed Sleep*

Sleep disturbances are extremely distressing to the family. If the patient is restless at night or wanders and talks at night, the entire family is disturbed. Sleep patterns must be maintained. Napping during the day should be avoided. Sleeping pills are best avoided as their effect is temporary and frequently unpredictable in patients of Alzheimer's disease. Causes of discomfort at night, such as pain, uncomfortable temperature or prostate trouble, should be checked.

### *Interpersonal Relationship*

Verbal communication should be clear and unhurried. Questions that require 'yes', or 'no' answers are best. Reinforce socially acceptable skills. Give necessary information repeatedly. Focus on things the person does well rather than on mistakes or failures. Try to make sure that each day has some thing of interest for the patient- it might be going for a walk, listening to music; talk about the day's activities. Try to involve him with old friends for a chat, reminiscing about the past.

Family members should be aware of early warning signs which may suggest that one of the older members may be on the verge of developing Alzheimer's disease. Early diagnosis and early intervention can be beneficial both to the patient and the family.

As the disease progresses, the family remains the main pillar of support for the patient.

Alzheimer's associations around the world provide practical and emotional help and information to families, health care professionals and the community. Alzheimer's and Related Disorders Society of India (ARDSI) started in 1992, a national organization dedicated to dementia care, support and research.

## **DELIRIUM (ACUTE ORGANIC BRAIN SYNDROME)**

Delirium is an acute organic mental disorder characterized by impairment of consciousness, disorientation and disturbances in perception and restlessness.

### *Incidence*

Delirium has the highest incidence among organic mental disorders. About 10 to 25% of medical-surgical inpatients, and about 20 to 40% of geriatric patients meet the criteria for delirium during hospitalization. This percentage is higher in post-operative patients.

### *Etiology*

- Vascular: hypertensive encephalopathy, cerebral arteriosclerosis, intracranial hemorrhage

- Infections: encephalitis, meningitis
- Neoplastic: space occupying lesions
- Intoxication: chronic intoxication or withdrawal effect of sedative-hypnotic drugs
- Traumatic: subdural and epidural hematoma, contusion, laceration, post-operative, heat-stroke
- Vitamin deficiency, e.g. thiamine
- Endocrine and metabolic: diabetic coma and shock, uremia, myxedema, hyperthyroidism, hepatic failure
- Metals: heavy metals (lead, manganese, mercury), carbon monoxide and toxins
- Anoxia: anemia, pulmonary or cardiac failure

### Clinical Features

- Impairment of consciousness: clouding of consciousness ranging from drowsiness to stupor and coma.
- Impairment of attention: difficulty in shifting, focusing and sustaining attention.
- Perceptual disturbances: illusions and hallucinations, most often visual.
- Disturbance of cognition: impairment of abstract thinking and comprehension, impairment of immediate and recent memory, increased reaction time.
- Psychomotor disturbance: hypo or hyperactivity, aimless groping or picking at the bed clothes (flocculation), enhanced startle reaction.
- Disturbance of the sleep-wake cycle: insomnia or in severe cases total sleep loss or reversal of sleep-wake cycle, daytime drowsiness, nocturnal worsening of symptoms, disturbing dreams or nightmares, which may continue as hallucinations after awakening.
- Emotional disturbances: depression, anxiety, fear, irritability, euphoria, apathy or wondering perplexity.

### Course and Prognosis

The onset is usually abrupt. The duration of an episode is usually brief, lasting for about a week.

### Treatment

- Identification of cause and its immediate correction, e.g., 50 mg of 50% dextrose IV for hypoglycemia, O<sub>2</sub> for hypoxia, 100 mg of B<sub>1</sub> IV for thiamine deficiency, IV fluids for fluid and electrolyte imbalance.
- Symptomatic measures: benzodiazepines (10 mg diazepam or 2 mg lorazepam IV) or antipsychotics (5 mg haloperidol or 50 mg chlorpromazine IM) may be given.

### Nursing Intervention

1. *Providing safe environment:*
  - restrict environmental stimuli, keep unit calm and well-illuminated
  - there should always be somebody at the patient's bedside reassuring and supporting
  - as the patient is responding to a terrifying unrealistic world of hallucinatory illusions and delusions, special precautions are needed to protect him from himself and to protect others
2. *Alleviating patient's fear and anxiety:*
  - remove any object in the room that seems to be a source of misinterpreted perception
  - as much as possible have the same person all the time by the patient's bedside
  - keep the room well lighted especially at night
3. *Meeting the physical needs of the patient:*
  - appropriate care should be provided after physical assessment
  - use appropriate nursing measures to reduce high fever, if present
  - maintain intake and output chart
  - mouth and skin should be taken care of
  - monitor vital signs
  - observe the patient for any extreme drowsiness and sleep as this may be an indication that the patient is slipping into a coma
4. *Facilitate orientation:*
  - repeatedly explain to the patient where he is and what date, day and time it is

- introduce people with name even if the patient misidentifies the people
- have a calendar in the room and tell him what day it is
- when the acute stage is over take the patient out and introduce him to others

### ORGANIC AMNESTIC SYNDROME

Organic amnestic syndrome is characterized by impairment of memory and global intellectual functioning due to an underlying organic cause. There is no disturbance of consciousness.

#### Etiology

- Thiamine deficiency, the most common cause being chronic alcoholism. It is also called as "Wernicke-Korsakoff syndrome." Wernicke's encephalopathy is an acute phase of delirium preceding amnestic syndrome, while Korsakoff's syndrome is a chronic phase of amnestic syndrome.
- Head trauma
- Bilateral temporal lobectomy
- Hypoxia
- Brain tumors
- Herpes simplex encephalitis
- Stroke.

#### Clinical Features

- Recent memory impairment
- Anterograde and retrograde amnesia
- There is no impairment of immediate memory

#### Management

- Treatment for underlying cause.

### MENTAL DISORDERS DUE TO BRAIN DAMAGE, DYSFUNCTION AND PHYSICAL DISEASE

These are mental disorders, which are causally related to brain dysfunction due to primary cerebral disease, systemic disease or toxic substances.

*Primary cerebral diseases:* Epilepsy, encephalitis, head trauma, brain neoplasms, vascular cerebral disease and cerebral malformations.

*Systemic diseases:* Hypothyroidism, Cushing's disease, hypoxia, hypoglycemia, systemic lupus erythematosus and extracranial neoplasms.

*Drugs:* Steroids, antihypertensives, antimalarials, alcohol and psychoactive substances.

The following mental disorders come under this category:

- Organic hallucinosis
- Organic catatonic disorder
- Organic delusional disorder
- Organic mood disorder
- Organic anxiety disorder.

### PERSONALITY AND BEHAVIORAL DISORDERS DUE TO BRAIN DISEASE, DAMAGE AND DYSFUNCTION

These disorders are characterized by significant alteration of the premorbid personality due to underlying organic cause. There is no disturbance of consciousness and global intellectual function. The personality change may be characterized by emotional lability, poor impulse control, apathy, hostility or accentuation of earlier personality traits.

#### Etiology

- Complex partial seizures (temporal lobe seizures)
- Cerebral neoplasms
- Cerebrovascular disease
- Head injury.

#### Management

- Treatment for the underlying cause.
- Symptomatic treatment with lithium, carbamazepine or with antipsychotics.

### REVIEW QUESTIONS

- Classification of organic mental disorders
- Dementia (Feb 2000, Feb 2001, Nov 2001, Apr 2002, Nov 2003, Oct 2004, Oct 2005, Oct 2006)
- Delirium (Oct 2004)
- Amnestic syndrome

# 9

## The Individual with Neurotic Disorder

- DIFFERENCES BETWEEN PSYCHOTIC AND NEUROTIC DISORDERS
- CLASSIFICATION
- PHOBIC ANXIETY DISORDER
- GENERALIZED ANXIETY DISORDER
- PANIC DISORDER
- OBSESSIVE-COMPULSIVE DISORDER (OCD)
- REACTION TO STRESS AND ADJUSTMENT DISORDER
- DISSOCIATIVE DISORDERS
- SOMATOFORM DISORDERS

Neurotic disorder (neurosis) is a less severe form of psychiatric disorder where patients show

either excessive or prolonged emotional reaction to any given stress. These disorders are not caused by organic disease of the brain and, however severe, do not involve hallucinations and delusions. They are classified under F4 in ICD10.

For differences between psychotic and neurotic disorder See Table 9.1.

### CLASSIFICATION [ICD10]

- Phobic anxiety disorder

**Table 9.1:** Differences between psychotic disorder (psychosis) and neurotic disorder (neurosis)

|   | <i>Psychotic disorder</i>  | <i>Neurotic disorder</i>   |
|---|--|--|
| <i>Etiology</i>                         |  |  |
| Genetic factors                         | more important   | less important   |
| Stressful life events                   | less important   | more important   |
| <i>Clinical features</i>                |  |  |
| Disturbances of thinking and perception | common   | rare   |
| Disturbances in cognitive function      | common   | rare   |
| Behavior                                | markedly affected  | not affected   |
| Judgment                                | impaired   | intact   |
| Insight                                 | lost   | present  |
| Reality testing                         | lost   | present  |
| <i>Treatment</i>                        |  |  |
| Drugs                                   | major tranquilizers commonly used  | minor tranquilizers and anti-depressants are commonly used                     |
| ECT                                     | very useful  | not useful   |
| Psychotherapy                           | not much useful  | very useful;   |
| <i>Prognosis</i>                        | difficult to treat; relapses are common; complete recovery may not be possible | relatively easy to treat; relapses are uncommon; complete recovery is possible |

- Other anxiety disorders
- Obsessive-compulsive disorder
- Reaction to severe stress and adjustment disorders
- Dissociative (conversion) disorders
- Somatoform disorder
- Other neurotic disorders

### PHOBIC ANXIETY DISORDER

Anxiety is a normal phenomenon, which is characterized by a state of apprehension or uneasiness arising out of anticipation of danger. Normal anxiety becomes pathological when it causes significant subject distress and impairment of functioning of the individual.

Anxiety disorders are abnormal states in which the most striking features are mental and physical symptoms of anxiety, which are not caused by organic brain disease or any other psychiatric disorder.

A phobia is an unreasonable fear of a specific object, activity or situation. This *irrational fear is characterized by the following features:*

- It is disproportionate to the circumstances that precipitate it.
- It cannot be dealt with by reasoning or controlled through will power.
- The individual avoids the feared object or situation.

In phobic anxiety disorders, the individual experiences intermittent anxiety which arises in particular circumstances, i.e. in response to the phobic object or situation.

#### Types of Phobia

- Simple phobia
- Social phobia
- Agoraphobia

*Simple phobia (Specific phobia)* Simple phobia is an irrational fear of a specific object or stimulus. Simple phobias are common in childhood. By early teenage most of these fears are lost, but a few persist till adult life. Sometimes they may reappear after a symptom-free period. Exposure to the phobic object often results in panic attacks.

*Examples of some specific phobias:*

- Acrophobia—fear of heights
- Hematophobia—fear of the sight of blood
- Claustrophobia—fear of closed spaces
- Gamophobia—fear of marriage
- Insectophobia—fear of insects
- AIDS phobia—fear of AIDS

*Social phobia* Social phobia is an irrational fear of performing activities in the presence of other people or interacting with others. The patient is afraid of his own actions being viewed by others critically, resulting in embarrassment or humiliation.

*Agoraphobia* It is characterized by an irrational fear of being in places away from the familiar setting of home, in crowds, or in situations that the patient cannot leave easily.

As the agoraphobia increases in severity, there is a gradual restriction in normal day-to-day activities. The activity may become so severely restricted that the person becomes self-imprisoned at home.

In all the above mentioned phobias, the individual experiences the same core symptoms as in generalized anxiety disorders. These are listed on page 114.

#### Etiology

*Psychodynamic theory* According to this theory, anxiety is usually dealt with repression. When repression fails to function adequately, other secondary defense mechanisms of ego come into action. In phobia, this secondary defence mechanism is displacement. By displacement anxiety is transferred from a really dangerous or frightening object to a neutral object. These two objects are connected by symbolic associations. The neutral object chosen unconsciously is the one that can be easily avoided in day-to-day activities, in contrast to the frightening object.

*Learning theory* According to classical conditioning a stressful stimulus produces an unconditioned response - fear. When the stressful stimulus is repeatedly paired with a harmless object, eventually the harmless object alone

produces the fear, which is now a conditioned response. If the person avoids the harmless object to avoid fear, the fear becomes a phobia.

**Cognitive theory** Anxiety is the product of faulty cognitions or anxiety-inducing self-instructions. Cognitive theorists believe that some individuals engage in negative and irrational thinking that produce anxiety reactions. The individual begins to seek out avoidance behaviors to prevent the anxiety reactions and phobias result.

### Course

The phobias are more common in women with an onset in late second decade or early third decade. Onset is sudden without any cause. The course is usually chronic. Sometimes phobias are spontaneous remitting.

### Treatment

#### Pharmacotherapy

- Benzodiazepines (e.g. alprazolam, clonazepam, lorazepam, diazepam)

- Antidepressants (e.g. imipramine, sertraline, phenelzine)

#### Behavior therapy

- Flooding
- Systematic desensitization
- Exposure and response prevention
- Relaxation techniques

#### Cognitive therapy

This therapy is used to break the anxiety patterns in phobic disorders.

**Psychotherapy** Supportive psychotherapy is a helpful adjunct to behavior therapy and drug treatment.

(Refer Chapter 14 for details of these therapies)

### Nursing Management

#### Nursing Assessment

Assessment parameters focus on physical symptoms, precipitating factors, avoidance behavior associated with phobia, impact of anxiety on

**Table 9.2:** Nursing interventions to reduce anxious behaviour

| <i>Interventions</i>   | <i>Rationale</i>   |
|--|--|
| (a) Reassure the patient that he is safe.  | At the panic level of anxiety patient may fear for his own life.   |
| (b) Explore patient's perception of the threat to physical integrity or threat to self concept.  | It is important to understand patient's perception of the phobic object or situation to assist with the desensitization process.                               |
| (c) Include patient in making decisions related to selection of alternative coping strategies (e.g. patient may choose either to avoid the phobic stimulus or attempt to eliminate the fear associated with it.) | Allowing the patient to choose provides a measure of control and serves to increase feelings of self-worth.  |
| (d) If the patient elects to work on eliminating the fear, techniques of desensitization or implosion therapy may be employed.   | Fear decreases as the physical and psychological sensations diminish in response to repeated exposure to the phobic stimulus under non-threatening conditions. |
| (e) Encourage patient to explore underlying feelings that may be contributing to irrational fears.   | Facing these feelings rather than suppressing them may result in more adaptive coping abilities.   |

**Table 9.3:** Nursing interventions to reduce social isolation behaviour in anxious patients

| <i>Interventions</i>   | <i>Rationale</i>   |
|--|--|
| (a) Convey an accepting attitude and unconditional positive regard. Make brief, frequent contacts. Be honest and keep all promises.                          | These interventions increase feelings of self-worth and facilitate a trusting relationship.                                      |
| (b) Attend group activities with the patient that may be frightening for him.  | The presence of a trusted individual provides emotional security.  |
| (c) Administer anti-anxiety medications as ordered by the physician, monitor for effectiveness and adverse affects.  | Anti-anxiety medications help to reduce the level of anxiety in most individuals, thereby facilitating interactions with others. |
| (d) Discuss with the patient signs and symptoms of increasing anxiety and techniques to interrupt the response.(e.g. relaxation exercises, thought stopping) | Maladaptive behavior such as withdrawal and suspiciousness are manifested during times of increased anxiety.                     |
| (e) Give recognition and positive reinforcement for voluntary interactions with others.  | To enhance self-esteem encourage repetition of acceptable behaviors.   |

physical functioning, normal coping ability, thought content and social support systems.

#### *Nursing Diagnosis I*

Fear related to a specific stimulus (simple phobia), or causing embarrassment to self in front of others, evidenced by behavior directed towards avoidance of the feared object/situation.

*Objective:* Patient will be able to function in the presence of a phobic object or situation without experiencing panic anxiety.

*Intervention:* See Table 9.2.

#### *Nursing Diagnosis II*

Social isolation related to fear of being in a place from which one is unable to escape, evidenced by staying alone, refusing to leave the room/home.

*Objective:* Patient will voluntarily participate in group activities with peers.

*Intervention:* See Table 9.3.

#### *Evaluation*

Reassessment is conducted to determine if the nursing interventions have been successful in

achieving the objectives of care. Following questions are helpful in evaluation:

- Does the patient face phobic object/situation without anxiety?
- Does the patient voluntarily participate in group activities?
- Is the patient able to demonstrate techniques that he may use to prevent anxiety from escalating to the panic level?

#### **GENERALIZED ANXIETY DISORDER**

Generalized anxiety disorders are those in which anxiety is unvarying and persistent (unlike phobic anxiety disorders where anxiety is intermittent and occurs only in the presence of a particular stimulus). It is the most common neurotic disorder, and it occurs more frequently in women. The prevalence rate of generalized anxiety disorders is about 2.5–8%.

#### **Clinical Features**

Generalized anxiety disorder (GAD) is manifested by the following signs of motor tension, autonomic hyperactivity, apprehension and vigilance, which should last for at least 6 months in order to make a diagnosis:

**Psychological:** Fearful anticipation, irritability, sensitivity to noise, restlessness, poor concentration, worrying thoughts and apprehension.

### Physical:

- Gastrointestinal—dry mouth, difficulty in swallowing, epigastric discomfort, frequent or loose motions
- Respiratory—constriction in the chest, difficulty inhaling, overbreathing
- Cardiovascular—palpitations, discomfort in chest
- Genitourinary—frequency or urgent micturition, failure of erection, menstrual discomfort, amenorrhea
- Neuromuscular system—tremor, prickling sensations, tinnitus, dizziness, headache, aching muscles
- Sleep disturbances—insomnia, night terror
- Other symptoms: depression, obsessions, depersonalization, derealization

### Course

It is characterized by an insidious onset in the third decade and usually runs a chronic course.

### PANIC DISORDER

Panic disorder is characterized by anxiety, which is intermittent and unrelated to particular circumstances (unlike phobic anxiety disorders where, though anxiety is intermittent, it occurs only in particular situations). The central feature is the occurrence of panic attacks, i.e. sudden attacks of anxiety in which physical symptoms predominate and are accompanied by fear of a serious consequence such as a heart attack. The lifetime prevalence of panic disorder is 1.5 to 2 percent. It is seen 2 to 3 times more often in females.

### Clinical Features

- Shortness of breath and smothering sensations
- Choking, chest discomfort or pain
- Palpitations
- Sweating, dizziness, unsteady feelings or faintness
- Nausea or abdominal discomfort

- Depersonalization or derealization
- Numbness or tingling sensations
- Flushes or chills
- Trembling or shaking
- Fear of dying
- Fear of going crazy or doing something uncontrolled

### Course

The onset is usually in early third decade with often a chronic course. It occurs recurrently every few days. The episode is usually sudden in onset and lasts for a few minutes.

### Etiology of Anxiety Disorders (both GAD and panic disorder)

- *Genetic theory:* Anxiety disorder is most frequent among relatives of patients with this condition. About 15 to 20% of the first-degree relatives of patients with anxiety disorder exhibit anxiety disorders themselves. The concordance rate in monozygotic twins of patients with panic disorder is 80 percent.
- *Biochemical factors:* Alteration in GABA levels may lead to production of clinical anxiety.
- *Psychodynamic theory:* According to this theory anxiety is usually dealt with repression. When repression fails to function adequately, other secondary defense mechanisms of ego come into action. In anxiety repression fails to function adequately and the secondary defense mechanisms are not activated. Hence anxiety comes to the forefront.
- *Behavioral theory:* Anxiety is viewed as an unconditional inherent response of the organism to a painful stimulus.
- *Cognitive theory:* According to this theory anxiety is related to cognitive distortions and negative automatic thoughts.

### Treatment

#### *Pharmacotherapy*

- Benzodiazepines (e.g. alprazolam, clonazepam)
- Antidepressants for panic disorder

- Beta-blockers to control severe palpitations that have not responded to anxiolytics (e.g. propranolol)

#### *Behavioral therapies*

- Bio-feedback
- Hyperventilation control

#### *Other psychological therapies*

- Jacobson's progressive muscle relaxation technique, yoga, pranayama, meditation and self-hypnosis
- Supportive psychotherapy

### Nursing Management

#### *Nursing Assessment*

Assessment should focus on collection of physical, psychological and social data. The nurse should be particularly aware of the fact that major physical symptoms are often associated with

autonomic nervous system stimulation. Specific symptoms should be noted, along with statements made by the client about subjective distress. The nurse must use clinical judgment to determine the level of anxiety being experienced by the client.

#### *Nursing Diagnosis I*

Panic anxiety related to real or perceived threat to biological integrity or self-concept, evidenced by various physical and psychological manifestations.

*Objective:* Patient will be able to recognize symptoms of onset on anxiety and intervene before reaching panic level.

*Intervention:* See Table 9.4.

#### *Nursing Diagnosis II*

Powerlessness related to impaired cognition, evidenced by verbal expression of lack of control

**Table 9.4:** Nursing interventions to reduce panic anxiety

| <i>Interventions</i>   | <i>Rationale</i>   |
|--|--|
| (a) Stay with the patient and offer reassurance of safety and security.  | Presence of trusted individual provides feeling of security and assurance of personal safety.  |
| (b) Maintain a calm, non-threatening matter-of-fact approach.  | Anxiety is contagious and may be transferred from staff to patient or vice-versa.  |
| (c) Use simple words and brief messages, spoken calmly and clearly to explain hospital experiences.  | In an intensely anxious situation, patient is unable to comprehend anything but the most elementary communication.   |
| (d) Keep immediate surroundings low in stimuli (dim lighting, few people).   | A stimulating environment may increase of anxiety level.   |
| (e) Administer tranquilizing medication as prescribed by physician. Assess for effectiveness and for side-effects.   | Anti-anxiety medication provides relief from the immobilizing effects of anxiety.  |
| (f) When level of anxiety has been reduced, explore possible reasons for occurrence.   | Recognition of precipitating factors is the first step in teaching patient to interrupt escalating anxiety.  |
| (g) Teach signs and symptoms of escalating anxiety and ways to interrupt its progression (relaxation techniques, deep-breathing exercises and meditation, or physical exercise like brisk walks and jogging. | The first three of these activities result in physiologic response opposite of the anxiety response, i.e. a sense of calm, slowed heart rate, etc. The latter activities discharge energy in a healthy manner. |

**Table 9.5:** Nursing interventions to improve self-control in anxious patients

| <i>Interventions</i>   | <i>Rationale</i>   |
|--|--|
| (a) Allow patient to take as much responsibility as possible for self-care activities, provide positive feedback for decisions made.                         | Providing choices will increase patient's feeling of control.  |
| (b) Assist patient to set realistic goals.   | Unrealistic goals set the patient up for failure and reinforce feelings of powerlessness.  |
| (c) Help identify life situations that are within patient's control.   | Patient's emotional condition interferes with the ability to solve problems.   |
| (d) Help patient identify areas of life situation that are not within his ability to control. Encourage verbalization of feelings related to this inability. | Assistance is required to perceive the benefits and consequences of available alternatives accurately, to deal with unresolved issues and accept what cannot be changed. |

over life situations and non-participation in decision-making related to own care or significant life issues.

*Objective:* Patient will be able to effectively solve problems and take control of his life.

*Intervention:* See Table 9.5.

#### Evaluation

Identified objectives serve as the basis for evaluation. In general, evaluation of objectives for clients with anxiety disorders deals with questions such as the following:

- Is the client experiencing a reduced level of anxiety?
- Does the client recognize symptoms as anxiety-related?
- Is the client able to use newly learned behavior to manage anxiety?

### OBSESSIVE-COMPULSIVE DISORDER (OCD)

#### Definition

According to ICD9, obsessive-compulsive disorder is a state in which "the outstanding symptom is a feeling of subjective compulsion – which must be resisted – to carry out some action, to dwell on an idea, to recall an experience, or

ruminating on an abstract topic. Unwanted thoughts, which include the inconsistency of words or ideas are perceived by the patient to be inappropriate or nonsensical. The obsessional urge or idea is recognized as alien to the personality, but as coming from within the self. Obsessional rituals are designed to relieve anxiety, e.g. washing the hands to deal with contamination. Attempts to dispel the unwelcome thoughts or urges may lead to a severe inner struggle, with intense anxiety."

From the above, obsessions and compulsions should have the following characteristics:

- They are ideas, impulses or images, which intrude into conscious awareness repeatedly.
- They are recognized as the individual's own thoughts or impulses.
- They are unpleasant and recognized as irrational.
- Patient tries to resist them but is unable to.
- Failure to resist leads to marked distress.
- Rituals (compulsions) are performed with a sense of subjective compulsion (urge to act).
- They are aimed at either preventing or neutralizing the distress or fear arising out of obsessions.

The disorder may begin in childhood, but more often begins in adolescence or early

adulthood. It is equally common among men and women. The course is usually chronic.

### **Classification (ICD10)**

- OCD with predominantly obsessive thoughts or ruminations.
- OCD with predominantly compulsive acts.
- OCD with mixed obsessional thoughts and acts.

### **Etiology**

#### *Genetic Factors*

Twin studies have consistently found a significantly higher concordance rate for monozygotic twins than for dizygotic twins. Family studies of these patients have shown that 35% of the first-degree relatives of obsessive-compulsive disorder patients are also affected with the disorder.

#### *Biochemical Influences*

A number of studies suggest that the neurotransmitter serotonin (5-HT) may be abnormal in individuals with obsessive-compulsive disorder.

#### *Psychoanalytic Theory*

The psychoanalytic concept (Freud) views patients with obsessive-compulsive disorder (OCD) as having regressed to developmentally earlier stages of the infantile superego, whose harsh exacting punitive characteristics now reappear as part of the psychopathology.

Freud also proposed that regression to the pre-oedipal anal sadistic phase combined with the use of specific ego defense mechanisms like isolation, undoing, displacement and reaction formation, may lead to OCD.

#### *Behavior Theory*

This theory explains obsessions as a conditioned stimulus to anxiety. Compulsions have been described as learned behavior that decreases the anxiety associated with obsessions. This decrease in anxiety positively reinforces the compulsive

acts and they become stable learned behavior. This theory is more useful for treatment purposes.

### **Clinical Picture**

*Obsessional thoughts* These are words, ideas and beliefs that intrude forcibly into the patient's mind. They are usually unpleasant and shocking to the patient and may be obscene or blasphemous.

*Obsessional images* These are vividly imagined scenes, often of a violent or disgusting kind involving abnormal sexual practices.

*Obsessional ruminations* These involve internal debates in which arguments for and against even the simplest everyday actions are reviewed endlessly.

*Obsessional doubts* These may concern actions that may not have been completed adequately. The obsession often implies some danger such as forgetting to turn off the stove or not locking a door. It may be followed by a compulsive act such as the person making multiple trips back into the house to check if the stove has been turned off.

Sometimes these may take the form of doubting the very fundamentals of beliefs, such as, doubting the existence of God and so on.

*Obsessional impulses* These are urges to perform acts usually of a violent or embarrassing kind, such as injuring a child, shouting in church etc.

*Obsessional rituals* These may include both mental activities such as counting repeatedly in a special way or repeating a certain form of words, and repeated but senseless behaviors such as washing hands 20 or more times a day. Sometimes such compulsive acts may be preceded by obsessional thoughts; for example, repeated handwashing may be preceded by thoughts of contamination. These patients usually believe that the contamination is spread from object to object or person to person even by slight contact and may literally rub the skin off their hands by excessive hand washing.

*Obsessive slowness:* Severe obsessive ideas or extensive compulsive rituals characterize obsessional slowness in the relative absence of manifested anxiety. This leads to marked slowness in daily activities.

### Course and Prognosis

Course is usually long and fluctuating. About two-thirds of patients improve by the end of a year. A good prognosis is indicated by good social and occupational adjustment, the presence of a precipitating event and an episodic nature of symptoms.

Prognosis appears to be worse when the onset is in childhood, the personality is obsessional, symptoms are severe, compulsions are bizarre, or there is a coexisting major depressive disorder.

### Treatment

#### Pharmacotherapy

- Antidepressants (e.g. fluvoxamine, sertraline, etc.)
- Anxiolytics (e.g. benzodiazepines)

#### Behavior Therapy

- Exposure and response prevention
- Thought stoppage
- Desensitization
- Aversive conditioning

*Exposure and response prevention* This is vivo exposure procedure combined with response prevention techniques. For example compulsive handwashers are encouraged to touch contaminated objects and then refrain from washing in order to break the negative reinforcement chain (hand washing reducing the anxiety i.e. negative reinforcement).

*Thought stoppage* Thought stopping is a technique to help an individual to learn to stop thinking unwanted thoughts. Following are the steps in thought stopping:

- Sit in a comfortable chair, bring to mind the unwanted thought concentrating on only one thought per procedure.

- As soon as the thought forms, give the command 'Stop!' Follow this with calm and deliberate relaxation of muscles and diversion of thought to something pleasant.
- Repeat the procedure to bring the unwanted thought under control.

(Refer Chapter 14 for desensitization and aversive conditions)

#### Other Therapies

- Supportive psychotherapy.
- ECT—for patients refractory to other forms of treatment.

### Nursing Management

#### Nursing Assessment

Assessment should focus on the collection of physical, psychological and social data. The nurse should be particularly aware of the impact of obsessions and compulsions on physical functioning, mood, self-esteem and normal coping ability. The defense mechanisms used, thought content or process, potential for suicide, ability to function and social support systems available should also be noted.

#### Nursing Diagnosis I

Ineffective individual coping related to under-developed ego, punitive superego, avoidance learning, possible biochemical changes, evidenced by ritualistic behavior or obsessive thoughts.

*Objective:* Patient will demonstrate ability to cope effectively without resorting to obsessive-compulsive behaviors.

*Intervention:* See Table 9.6.

#### Nursing Diagnosis II

Altered role performance related to the need to perform rituals, evidenced by inability to fulfil usual patterns of responsibility.

*Objective:* Patient will be able to resume role-related responsibilities.

*Intervention:* See Table 9.7.

**Table 9.6:** Nursing interventions to reduce obsessive compulsive behaviour

| Interventions  | Rationale  |
|--|--|
| (a) Work with patient to determine types of situations that increase anxiety and result in ritualistic behaviors.  | Recognition of precipitating factors is the first step in teaching the patient to interrupt escalating anxiety.  |
| (b) Initially meet the patient's dependency needs. Encourage independence and give positive reinforcement for independent behaviors.                       | Sudden and complete elimination of all avenues for dependency would create intense anxiety on the part of the patient. Positive reinforcement enhances self-esteem and encourages repetition of desired behaviors. |
| (c) In the beginning of treatment, allow plenty of time for rituals. Do not be judgmental or verbalize disapproval of the behavior.                        | Denying patient this activity may precipitate panic anxiety.   |
| (d) Support patient's efforts to explore the meaning and purpose of the behavior.  | Patient may be unaware of the relationship between emotional problems and compulsive behaviors. Recognition is important before change can occur.  |
| (e) Provide structured schedule of activities for patient, including adequate time for completion of rituals.  | Structure provides a feeling of security for the anxious patient.  |
| (f) Gradually begin to limit amount of time allotted for ritualistic behavior as patient becomes more involved in unit activities.                         | Anxiety is minimized when patient is able to replace ritualistic behaviors with more adaptive ones.  |
| (g) Give positive reinforcement for non-ritualistic behaviors.   | Positive reinforcement encourages repetition of desired behaviors.   |
| (h) Help patient learn ways of interrupting obsessive thoughts and ritualistic behavior with techniques such as thought stopping, relaxation and exercise. | These activities help in interruption of obsessive thoughts.   |

**Table 9.7:** Nursing interventions to improve role-related responsibilities in OCD patients

| Interventions  | Rationale   |
|--|---|
| (a) Determine patient's previous role within the family and the extent to which this role is altered by the illness. Identify roles of other family members. | This is important assessment data for formulating an appropriate plan of care.  |
| (b) Encourage patient to discuss conflicts evident within the family system. Identify how patient and other family members have responded to this conflict.  | Identifying specific stressors, as well as adaptive and maladaptive responses within the system, is necessary before assistance can be provided in an effort to facilitate change. Planning and rehearsal of potential role transitions can reduce anxiety. |
| (c) Explore available options for changes or adjustments in role. Practice through role play.  |   |
| (d) Give patient lots of positive reinforcement for ability to resume role responsibilities by decreasing need for ritualistic behaviors.                    | Positive reinforcement enhances self-esteem and promotes repetition of desired behaviors.   |

### Evaluation

Evaluation of client with obsessive-compulsive disorder may be done by asking the following questions:

- Does the client continue to display obsessive-compulsive symptoms?
- Is the client able to use newly learned behaviors to manage anxiety?
- Can the client adequately perform self-care activities?

### REACTION TO STRESS AND ADJUSTMENT DISORDER

This category includes:

- Acute stress reaction
- Post-traumatic stress disorder (PTSD)
- Adjustment disorders

#### Acute Stress Reaction

It is characterized by symptoms like anxiety, despair and anger or over activity. These symptoms are clearly related to the stressor. If removal from the stressful environment is possible, the symptoms resolve rapidly.

#### Post-traumatic Stress Disorder (PTSD)

Post-traumatic stress disorder is characterized by hyperarousal, re-experiencing of images of the stressful events and avoidance of reminders.

Post-traumatic stress disorder is of a reaction to extreme stressors such as floods, earthquakes, war, rape or serious physical assault. The main symptoms are persistent anxiety, irritability, insomnia, intense intrusive imagery (flashbacks) recurring distressing dreams, inability to feel emotion and diminished interest in activities.

The symptoms may develop after a period of latency, within 6 months after the stress or may be delayed. The general approach is to provide emotional support, to encourage recall of the traumatic events. Benzodiazepine drugs may be needed to reduce anxiety.

### Adjustment Disorders

It is characterized by predominant disturbance of emotions and conduct. This disorder usually occurs within one month of a significant life change.

### Treatment for Stress and Adjustment Disorders

#### Drug treatment

- Antidepressants
- Benzodiazepines

#### Psychological therapies

- Supportive psychotherapy
- Crisis intervention
- Stress management training

### DISSOCIATIVE (CONVERSION) DISORDERS

Conversion disorder is characterized by the presence of one or more symptoms suggesting the presence of a neurological disorder that cannot be explained by any known neurological or medical disorder. Instead, psychological factors like stress and conflicts are associated with onset or exacerbation of the symptoms. Patients are unaware of the psychological basis and are thus not able to control their symptoms.

Some features of the disorder include:

- The symptoms are produced because they reduce the anxiety of the patient by keeping the psychological conflict out of conscious awareness, a process called as *primary gain*.
- These symptoms of conversion are often advantageous to the patient. For example, a woman who develops psychogenic paralysis of the arm may escape from taking care of an elderly relative. Such an advantage is called as *secondary gain*.
- The patient does not produce the symptoms intentionally.
- The patient shows less distress or shows lack of concern about the symptoms, called as *belle indifference*.
- Physical examination and investigations do not reveal any medical or neurological abnormalities.

Conversion disorders were formerly called as 'hysteria.' The term is now changed because the word 'hysteria' is used in everyday speech when referring to any extravagant behavior, and it is confusing to use the same word for a different phenomena that falls under this syndrome.

### **Dissociative Amnesia**

Most often, dissociative amnesia follows a traumatic or stressful life situation. There is sudden inability to recall important personal information particularly concerning the stressful life event. The extent of the disturbance is too great to be explained by ordinary forgetfulness. The amnesia may be localized, generalized, selective or continuing in nature.

### **Dissociative Fugue**

Psychogenic fugue is a sudden, unexpected travel away from home or workplace, with the assumption of a new identity and an inability to recall the past. The onset is sudden, often in the presence of severe stress. Following recovery there is no recollection of the events that took place during the fugue. The course is typically a few hours to days and sometimes months.

### **Dissociative Stupor**

In this, patients are motionless and mute and do not respond to stimulation, but they are aware of their surroundings. It is a rare condition.

### **Ganser's Syndrome**

Ganser's syndrome is a rare condition with four features: giving 'approximate answers' to questions designed to test intellectual functions, psychogenic physical symptoms, hallucinations and apparent clouding of consciousness. The term 'approximate answers' denotes answers (to simple questions) that are plainly wrong, but are clearly related to the correct answers in a way that suggest that the latter is known. For example, when asked to add three and three a patient might answer seven and when asked four and five, might answer ten; each answer is one greater than the

correct answer. Hallucinations are usually visual and may be elaborate.

### **Multiple Personality Disorder (Dissociative Identity Disorder)**

In this disorder, the person is dominated by two or more personalities of which only one is manifest at a time. Usually one personality is not aware of the existence of the other personalities. Each personality has a full range of higher mental functions and performs complex behavior patterns. Transition from one personality to another is sudden, and the behavior usually contrasts strikingly with the patient's normal state.

### **Trance and Possession Disorders**

This disorder is very common in India. It is characterized by a temporary loss of both the sense of personal identity and full awareness of the person's surroundings. When the condition is induced by religious rituals, the person may feel taken over by a deity or spirit. The focus of attention is narrowed to a few aspects of the immediate environment, and there is often a limited but repeated set of movements, postures and utterances.

### **Dissociative Motor Disorders**

It is characterized by motor disturbances like paralysis or abnormal movements. Paralysis may be a monoplegia, paraplegia or quadriplegia. The abnormal movement may be tremors, choreiform movements or gait disturbances which increase when attention is directed towards them. Examination reveals normal tone and reflexes.

### **Dissociative Convulsions (hysterical fits or pseudo-seizures)**

It is characterized by convulsive movements and partial loss of consciousness. Differential diagnosis with true seizures is important. Some differences are illustrated in Table 9.8.

### **Dissociative Sensory Loss and Anesthesia**

It is characterized by sensory disturbances like hemianesthesia, blindness, deafness and glove

**Table 9.8:** Differences between epileptic seizures and dissociative convulsions

| Clinical points                 | Epileptic seizures                   | Dissociative convulsions  |
|---------------------------------|--------------------------------------|---|
| Aura (warning)                  | usual                                | unusual   |
| Attack pattern                  | stereotyped known clinical pattern   | purposive body movements; absence of any established clinical pattern |
| Tongue bite                     | present                              | absent  |
| Incontinence of urine and feces | can occur                            | very rare   |
| Injury                          | can occur                            | very rare   |
| Duration                        | usually about 30-70 sec              | 20-800 sec (prolonged)  |
| Amnesia                         | complete                             | partial   |
| Time of day                     | anytime; can occur during sleep also | never occurs during sleep   |
| Place of occurrence             | anywhere                             | usually indoors or in safe places                                     |
| Post-ictal confusion            | present                              | absent  |
| Neurological signs              | present                              | absent  |

and stocking anesthesia (absence of sensations at wrists and ankles).

The disturbance is usually based on patient's knowledge of that particular illness whose symptoms are produced. A detailed examination does not reveal any abnormalities.

### Etiology of Conversion Disorders

#### Psychodynamic Theory

In conversion disorder, the ego defense mechanisms involved are repression and conversion. Conversion symptoms allow a forbidden wish or urge to be partly expressed, but sufficiently disguised so that the individual does not have to face the unacceptable wish. The symptoms are symbolically related to the conflict.

#### Behavior Theory

According to this theory the symptoms are learnt from the surrounding environment. These symptoms bring about psychological relief by avoidance of stress. Conversion disorder is more common in people with histrionic personality traits.

#### Treatment

- Free association

- Hypnosis
- Abreaction therapy
- Supportive psychotherapy
- Behavior therapy (aversion therapy, operant conditioning, etc.)
- Drug therapy: Drugs have a very limited role. A few patients have anxiety and may need short-term treatment with benzodiazepines

### Nursing Intervention

- Monitor physician's ongoing assessments, laboratory reports and other data to rule out organic pathology.
- Identify primary and secondary gains.
- Do not focus on the disability; encourage patient to perform self-care activities as independently as possible. Intervene only when patient requires assistance.
- Do not allow the patient to use the disability as a manipulative tool to avoid participation in the therapeutic activities.
- Withdraw attention if the patient continues to focus on physical limitations.
- Encourage patient to verbalize fears and anxieties.

- Positive reinforcement for identification or demonstration of alternative adaptive coping strategies.
- Identify specific conflicts that remain unresolved and assist patient to identify possible solutions.
- Assist the patient to set realistic goals for the future.
- Help the patient to identify areas of life situation that are not within his ability to control. Encourage verbalization of feelings related to this inability.

## SOMATOFORM DISORDERS

These disorders are characterized by repeated presentation with physical symptoms which do not have any physical basis, and a persistent request for investigations and treatment despite repeated assurance by the treating doctors.

These disorders are divided into following categories:

- Somatization disorder
- Hypochondriasis
- Somatoform autonomic dysfunction
- Persistent somatoform pain disorder

### Somatization Disorder

Somatization disorder is characterized by chronic multiple somatic symptoms in the absence of physical disorder. The symptoms are vague, presented in a dramatic manner and involve multiple organ systems.

### Hypochondriasis

Hypochondriasis is defined as a persistent preoccupation with a fear or belief of having a serious disease despite repeated medical reassurance.

### Somatoform Autonomic Dysfunction

In this disorder, the symptoms are predominantly under autonomic control, as if they were due to a physical disorder. Some of them include palpita-

tions, hiccoughs, hyperventilation, irritable bowel, dysuria, etc.

### Persistent Somatoform Pain Disorder

The main feature in this disorder is severe, persistent pain without any physical basis. It may be of sufficient severity so as to cause social or occupational impairment. Preoccupation with the pain is common.

### Treatment

#### *Drug therapy*

- Antidepressants
- Benzodiazepines

#### *Psychological treatment.*

- Supportive psychotherapy
- Relaxation therapy

## REVIEW QUESTIONS

- Differences between psychotic and neurotic disorders (Feb 2001, Oct 2006)
- Classification of neurotic disorders
- Neurotic disorders (Nov 2002, Apr 2005)
- Phobia (Nov 2002, Apr 2003, Nov 2003, Apr 2004)
- Agoraphobia (Oct 2004)
- Panic disorder (Oct 2006)
- Anxiety neurosis (Apr 2006)
- Nursing management for a patient with acute anxiety state (Feb 1999, Nov 2001, Apr 2002, Nov 2003, Apr 2004, Oct 2004)
- Obsession (Apr 2002, Apr 2003)
- Obsessive compulsive disorders (Oct 2000, Nov 2002, Nov 2003, Oct 2005)
- Ritualistic behavior (Nov 2003)
- Dissociative (conversion) disorders (Oct 2000, Apr 2006)
- Differences between epileptic seizures and pseudo-seizures (Oct 2000)
- Somatoform disorders
- Multiple personality (Nov 2002)

# 10

# *Behavioral Syndromes Resulting from Physiological Disturbances*

- PSYCHOPHYSIOLOGICAL/PSYCHOSOMATIC DISORDERS
  - Common Examples of Psychophysiological Disorders
  - Nursing Management of Patient With Psychophysiological Disorder
- EATING DISORDERS
  - Anorexia Nervosa
  - Bulimia Nervosa
- SLEEP DISORDERS
  - Insomnia
  - Hypersomnia
  - Disorders of Sleep-Wake Schedule
  - Stage IV Sleep Disorders
  - Other Sleep Disorders

## **PSYCHOPHYSIOLOGICAL/PSYCHOSOMATIC DISORDERS**

The word 'psychosomatic' means mind and body. Psychosomatic disorders are those disorders in which the psychic elements are significant for initiating chemical, physiological or structural alterations, which in turn create the physical symptoms in the person.

The term 'psychosomatic' has now been replaced with 'psychophysiologic'.

There are three factors which must be present simultaneously for a person to develop a psychosomatic disorder:

1. The individual must have "biological predisposition".
2. The individual must have "personality vulnerability".
3. The individual must experience a significant psychosocial stress in his/her susceptible personality area.

## **Common Examples of Psychophysiological Disorders**

Franz Alexander, the father of psychosomatic medicine, described seven classical psychosomatic illnesses.

### *Cardiovascular Disorders*

- Essential hypertension
- Coronary artery disease
- Post-cardiac surgery delirium
- Migraine
- Mitral valve prolapse syndrome

### *Endocrine Disorders*

- Diabetes mellitus
- Hyperthyroidism
- Cushing's syndrome
- Pre-menopausal syndrome
- Amenorrhea
- Menorrhagia

### *Gastrointestinal Disorders*

- Esophageal reflux
- Peptic ulcer
- Ulcerative colitis
- Crohn's disease

### *Immune Disorders*

- Autoimmune disorders, e.g. systemic lupus erythematosus
- Allergic disorders, like bronchial asthma and hay fever
- Viral infections

### *Musculoskeletal Disorders*

- Rheumatoid arthritis

### *Respiratory Disorders*

- Bronchial asthma
- Hay fever
- Rhinitis

### *Skin Disorders*

- Psoriasis
- Pruritus
- Urticaria
- Acne vulgaris
- Warts

### **Treatment**

1. Relaxation techniques: This is one of the most important methods aimed at reducing anxiety or restlessness. They include:
  - Jacobson's progressive relaxation technique
  - Yoga
  - Auto hypnosis
  - Meditation
  - Bio-feedback
2. Behavior modification techniques
3. Individual therapy
4. Group therapy

### **Nursing Management**

#### *Assessment*

- Perform thorough physical assessment.
- Monitor laboratory values, vital signs, intake and out put and other assessments necessary to maintain an accurate ongoing appraisal.
- Assess patient's level of anxiety.
- Assess patient's level of knowledge regarding effects of psychological problems on the body.

#### *Nursing Diagnoses*

- Ineffective individual coping related to repressed anxiety and inadequate coping methods, evidenced by initiation or exacerbation of physical illness.

- Knowledge deficit related to psychological factors affecting physical condition, evidenced by various physical problems.

### *Interventions*

- Encourage patient to discuss current life situations that he perceives as stressful, and the feelings associated with each.
- Provide positive reinforcement for adaptive coping mechanisms identified or used. Suggest alternative coping strategies but allow patient to determine which can most appropriately be incorporated into his life style.
- Help patient to identify a resource person within the community (friend or significant others) to use as a support system for the expression of feelings.
- Have patient keep a diary of appearance, duration, and intensity of physical symptoms. A separate record of situations that the patient finds especially stressful should be kept.
- Help patient identify needs that are being met through the sick role. Together, formulate more adaptive means for fulfilling these needs, practice by role-playing.
- Provide instruction in assertive techniques, especially the ability to recognize the differences among passive, assertive, and aggressive behaviors and the importance of respecting the rights of others while protecting one's own basic rights.
- Discuss adaptive methods of stress management, such as relaxation techniques, physical exercises, meditation and breathing exercises.

## **EATING DISORDERS**

The two most important eating disorders are:

- Anorexia nervosa, and
- Bulimia nervosa

### **Anorexia Nervosa**

Anorexia nervosa is characterized by highly specific behavioral and psychopathological symptoms and significant somatic signs. Majority

are females and the onset is during adolescence. The core psychopathological feature is the dread of fatness, weight phobia and a drive for thinness.

### Etiology

- a. **Genetic causes:** Among female siblings of patients with established anorexia nervosa, 6-10 percent suffer from the condition compared to the 1-2 percent found in the general population of the same age (Strober, 1995).
- b. **A disturbance in hypothalamic function.**
- c. **Social factors:** There is a high prevalence of anorexia nervosa among female students and in occupational groups particularly concerned with weight (for example, dancers). Influence of mass media, beauty contests are other important social causes.
- d. **Individual psychological factors:** A disturbance of body image, a struggle for control and a sense of identity are important factors in the causation of anorexia nervosa. Traits of low self-esteem and perfectionism are often found.
- e. **Causes within the family:** Disturbance in family relationships, over-protection, family members having an unusual interest in food and physical appearance.

### Clinical Features

- There is an intense fear of becoming obese. This fear does not decrease even if the person loses weight grossly and becomes very thin.
- The body weight is 15 percent below the standard weight.
- There is a body image disturbance. The patient is unable to perceive the body size accurately.
- The pursuit of thinness may take several forms. Patients generally eat little and set themselves daily calorie limits (often between 600 and 1000 calories). Some try to achieve weight loss by inducing vomiting, excessive exercise, and misusing laxatives.
- Other signs and symptoms are secondary to starvation and include sensitivity to cold, delayed gastric emptying, constipation, low

blood pressure, bradycardia, hypothermia and amenorrhea in females.

- Vomiting and abuse of laxatives may lead to a variety of electrolyte disturbances, the most serious being hypokalemia.
- Hormonal abnormalities also may be seen.

### Course and Prognosis

Anorexia nervosa often runs a fluctuating course with periods of exacerbations and partial remissions. Outcome is very variable.

### Treatment

#### Pharmacotherapy

- Neuroleptics
- Appetite stimulants
- Antidepressants

#### Psychological therapies

- Individual psychotherapy
- Behavioral therapy
- Cognitive behavior therapy
- Family therapy

### Nursing Interventions

- Short-term management is focused on ensuring weight gain and correcting nutritional deficiencies. Maintaining normal weight and preventing relapses are long-term goals to be achieved.
- Hospitalization is usually required and successful treatment depends on good nursing care, with clear aims and understanding on the part of the patient as well as the nurse.
- Eating must be supervised by the nurse and a balanced diet of at least 3000 calories should be provided in 24 hours.
- In the early stages of treatment, it is best for the patient to remain in bed in a single room while the nurse maintains close observation. The goal should be to achieve a weight gain of 0.5 to 1 kg per week.
- Weight should be checked regularly. Monitor serum electrolyte levels and signs and symptoms like amenorrhea, constipation, hypoglycemia, hypotension, etc.

- Control vomiting by making the bathroom inaccessible for at least 2 hours after food.
- In extreme cases when the patient refuses to eat and comply with the treatment, gavage feedings may need to be instituted.

### Bulimia Nervosa

Bulimia nervosa is described as repeated bouts of overeating and a preoccupation with control of weight that leads to self-induced vomiting.

#### Clinical Features

- An irresistible craving for food: There are episodes of overeating in which large amount of food are consumed within short periods of time (eating binges)
- Attempt to counteract the effects of overeating by self-induced vomiting
- There is usually no significant weight loss

#### Treatment

- Antidepressants, carbamazepine and lithium for patients with co-morbid mood disorders
- Group therapy
- Family therapy
- Cognitive behavior therapy

## SLEEP DISORDERS

Sleep can be regarded as a physiological reversible reduction of conscious awareness.

Sleep disorders are divided into subtypes:

### 1. Dyssomnias

- Insomnia
- Hypersomnia
- Disorders of sleep-wake schedule

### 2. Parasomnias

- Stage IV disorders
- Other disorders

## DYSSOMNIAS

### Insomnia

Insomnia is disorder of initiation and mainte-

nance of sleep. This includes frequent awakening during the night and early morning awakening.

#### Causes

##### Medical illnesses

- Any painful or uncomfortable illness
- Heart disease
- Respiratory diseases
- Brain stem or hypothalamic lesions
- Delirium
- Rheumatic and other musculoskeletal diseases
- Periodic movements in sleep
- Old age

##### Alcohol and drug use

- Delirium tremens
- Amphetamines or other stimulants
- Chronic alcoholism

##### Psychiatric disorders

- Mania (due to decreased need for sleep)
- Major depression (early morning awakening or *late insomnia*)
- Dysthymia or neurotic depression (difficulty in initiating sleep or *early insomnia*)
- Schizophrenia and other psychoses (due to psychotic symptoms)
- Anxiety disorder (difficulty in initiating sleep due to worrying thoughts)

#### Social causes

- Financial loss
- Separation or divorce
- Death of spouse or a close relative
- Retirement
- Stressful life situations

#### Behavioral causes

- Naps during the day
- Irregular sleeping hours
- Lack of physical exercise
- Excessive intake of beverages in the evening, e.g. coffee
- Disturbing environment (heat, cold, noise)

#### Treatment

- A thorough medical and psychiatric assessment; polysomnography may be needed in some cases.

- Treatment of underlying physical or psychiatric disorder.
- Withdrawal of current medications, if any.
- Transient insomnia can be treated initially with hypnotics.

### *Non-drug treatment for insomnia*

- Progressive relaxation.
- Autosuggestion.
- Meditation, yoga.
- Stimulus control therapy: do not use the bed for reading or chatting - go to bed for sleep only.

### *Sleep hygiene*

- Regular, daily physical exercises in the evening.
- Avoid fluid intake and heavy meals just before bedtime.
- Avoid caffeine intake (e.g. tea, coffee, cola drinks) before sleeping hours.
- Avoid reading or watching television while in bed.
- Back rubs, warm milk and relaxation exercises.
- Sleep in a comfortable environment.

### **Hypersomnia**

Hypersomnia is known as Disorder Of Excessive Somnolence (DOES). It includes excessive daytime sleepiness, sleep attacks during daytime, sleep drunkenness (person needs much more time to awaken, and during this period he is confused or disoriented).

#### **Causes**

Narcolepsy—excessive daytime sleepiness characterized by:

- Sleep attacks.
- Cataplexy—sudden decreased or loss of (sleep paralysis) muscle tone, often generalized and may lead on to sleep.
- Sleep paralysis—it occurs either at awakening

in morning or at sleep onset. The person is conscious but unable to move his body.

- Hypnagogic hallucinations
- 2. Sleep apnea: repeated episodes of apnea during sleep.
- 3. Kleine-Levin syndrome: periodic episodes of hypersomnia.

### **Disorder of Sleep-wake Schedule**

The person with this disorder is not able to sleep when he wishes to, although at other time he is able to sleep adequately.

#### **Causes**

- Work shifts
- Unusual sleep phases

### **PARASOMNIAS**

In this the person frequently wakes during sleep.

### **Stage IV Sleep Disorders**

- Sleep walking (somnambulism)
- Night terrors
- Sleep-related enuresis
- Bruxism (tooth-grinding)
- Sleep talking (somniloquy)

### **Other Sleep Disorders**

- Nocturnal angina
- Nocturnal asthma
- Nocturnal seizures
- Sleep paralysis

### **REVIEW QUESTIONS**

- Psychophysiological disorders (Feb 2001, Nov 2002)
- Dynamics of psychophysiological disorders (Apr 2006)
- Anorexia nervosa (Apr 2006)
- Insomnia (Nov 1999, Oct 2004)

# 11

## *Disorders due to Psychoactive Substance Use*

- ETIOLOGICAL FACTORS IN SUBSTANCE USE
- ALCOHOL DEPENDENCE SYNDROME
  - Medical and Social Complications of Alcohol Dependence
  - Psychiatric Disorders due to Alcohol Dependence
    - Acute Intoxication
    - Withdrawal Syndrome
    - Alcohol Induced Amnestic Disorder
    - Alcohol Induced Psychiatric Disorder
  - Treatment
  - Agencies Concerned With Alcohol-Related Problems
- OTHER SUBSTANCE USE DISORDERS
  - Opioid Use Disorders
  - Cannabis Use Disorder
  - Cocaine Use Disorder
  - Amphetamine Use Disorder
  - LSD Use Disorder
  - Barbiturate Use Disorder
  - Inhalants Or Volatile Solvent Use Disorder
- PREVENTION
- REHABILITATION
- NURSING MANAGEMENT FOR SUBSTANCE USE DISORDER

Disorders due to psychoactive substance use refer to conditions arising from the abuse of alcohol, psychoactive drugs and other chemicals such as volatile solvents. These are classified under F1 in ICD10.

*Abuse:* It refers to maladaptive pattern of substance use that impairs health in a broad sense.

*Dependence:* It refers to certain physiological and psychological phenomena induced by the repeated taking of a substance. The criteria for diagnosing dependence include (ICD10):

- A strong desire to take the substance

- Difficult in controlling substance taking behavior
- A physiological withdrawal state
- Development of tolerance
- Progressive neglect of alternative pleasures or interests
- Persisting with substance use despite clear evidence of harmful consequences

*Tolerance:* It is a state in which after repeated administration, a drug produces a decreased effect, or increasing doses are required to produce the same effect.

*Withdrawal state:* A group of signs and symptoms recurring when a drug is reduced in amount or withdrawn, which last for a limited time. The nature of the withdrawal state is related to the class of substance used.

The major dependence producing drugs are:

- Alcohol
- Opioids
- Cannabis
- Cocaine
- Amphetamines and other sympathomimetics
- Hallucinogens, e.g. LSD, phencyclidine
- Sedatives and hypnotics, e.g. barbiturates
- Inhalants, e.g. volatile solvents
- Nicotine
- Other stimulants, e.g. caffeine

### **ETIOLOGICAL FACTORS IN PSYCHOACTIVE SUBSTANCE USE**

#### *Biological Factors*

- Genetic vulnerability: family history of substance use disorder, e.g. twin studies suggest

that genetic mechanisms might account for alcohol consumption.

- Biochemical factors: for example, role of dopamine and norepinephrine have been implicated in cocaine, ethanol and opioid dependence. Abnormalities in alcohol dehydrogenase or in the neurotransmitter mechanism are thought to play a role in alcohol dependence.
- Withdrawal and reinforcing effects of drugs (they serve as maintaining factors).
- Co-morbid medical disorder (e.g. to control chronic pain).

### *Psychological Factors*

- General rebelliousness
- Sense of inferiority
- Poor impulse control
- Low self-esteem
- Inability to cope with the pressures of living and society (poor stress management skills)
- Loneliness, unmet needs
- Desire to escape from reality
- Desire to experiment, a sense of adventure
- Pleasure-seeking
- Machoism
- Sexual immaturity

### *Social Factors*

- Religious reasons
- Peer pressure
- Urbanization
- Extended periods of education
- Unemployment
- Overcrowding
- Poor social support
- Effects of television and other mass media
- Occupation: substance use is more common in chefs, bartenders, executives, salesmen, actors, entertainers, army personnel, journalists, medical personnel, etc

### *Easy Availability of Drugs*

- Taking drugs prescribed by doctors (e.g. benzodiazepine dependence).

- Taking drugs that can be bought legally without prescription (e.g. nicotine, opioids).
- Taking drugs that can be obtained from illicit sources (e.g. street drugs).

*Psychiatric disorders* Substance use disorders are more common in depression, anxiety disorders (particularly social phobias), personality disorder (especially antisocial personality) and occasionally in organic brain disease and schizophrenia.

### **ALCOHOL DEPENDENCE SYNDROME**

Alcoholism refers to the use of alcoholic beverages to the point of causing damage to the individual, society or both.

### **Properties of Alcohol**

Alcohol is a clear colored liquid with a strong burning taste. The rate of absorption of alcohol into the blood stream is more rapid than its elimination. Absorption of alcohol into the blood stream is slower when food is present in the stomach. A small amount is excreted through urine and a small amount is exhaled.

A concentration of 80 to 100 mg of alcohol per 100 ml of blood is considered intoxication. A person with 200 mg to 250 mg will be toxic, sleepy, confused and his thought process will be altered. If blood level is 300 mg / 100 ml of blood the person may lose consciousness. A concentration of 500 mg / 100 ml is fatal. All the symptoms change according to tolerance.

### **Epidemiology**

The incidence of alcohol dependence is 2%. In India 20 to 40% of subjects aged above 15 years are current users of alcohol, and nearly 10% of them are regular or excessive users. Nearly 15 to 30% of patients are developing alcohol-related problems and seeking admission in psychiatric hospitals.

## Medical and Social Complications of Alcohol Dependence

### A. Medical

#### *Gastrointestinal system*

- Gastritis, peptic ulcer, reflux esophagitis, carcinoma of stomach and esophagus
- Fatty liver, cirrhosis of liver, hepatitis, liver cell carcinoma
- Acute and chronic pancreatitis
- Malabsorption syndrome

#### *Cardiovascular system*

- Alcoholic cardiomyopathy
- High risk for myocardial infarction

#### *Central nervous system*

- Peripheral neuropathy
- Epilepsy
- Head injury
- Cerebellar degeneration

#### *Miscellaneous*

- Protein malnutrition
- Vitamin deficiency disorder
- Peripheral muscle weakness
- Acne
- Sexual dysfunction in males, failure of ovulation in females

#### *Damage to the fetus*

Fetal alcohol syndrome (facial abnormality, low birthweight, low intelligence), increased stillbirths. Alcohol dependence is responsible for 3 percent of all cases of mental retardation

### B. Social

- Marital disharmony
- Occupational problems
- Financial problems
- Criminality
- Accidents

## PSYCHIATRIC DISORDERS DUE TO ALCOHOL DEPENDENCE

1. Acute intoxication
2. Withdrawal syndrome
3. Alcohol induced amnestic disorders
4. Alcohol induced psychiatric disorders

1. **Acute intoxication:** Acute intoxication develops during or shortly after alcohol ingestion. It is characterized by clinically significant maladaptive behavior or psychological changes, e.g. inappropriate sexual or aggressive behavior, mood lability, impaired judgment, slurred speech, incoordination, unsteady gait, nystagmus, impaired attention and memory finally resulting in stupor or coma.

2. **Withdrawal syndrome:** In persons who have been drinking heavily over a prolonged period of time, any rapid decrease in the amount of alcohol in the body is likely to produce withdrawal symptoms. These are:

- Simple withdrawal syndrome
- Delirium tremens

**Simple withdrawal syndrome:** It is characterized by mild tremors, nausea, vomiting, weakness, irritability, insomnia and anxiety.

**Delirium tremens:** It occurs usually within 2-4 days of complete or significant abstinence from heavy alcohol drinking. The course is short, with recovery occurring within 3-7 days.

It is characterized by:

- A dramatic and rapidly changing picture of disordered mental activity, with clouding of consciousness and disorientation in time and place
- Poor attention span
- Vivid hallucinations which are usually visual; tactile hallucinations can also occur
- Severe psychomotor agitation, shouting and evident fear
- Grossly tremulous hands which sometimes pick up imaginary objects; truncal ataxia
- Autonomic disturbances such as sweating, fever, tachycardia, raised blood pressure, pupillary dilatation
- Dehydration with electrolyte imbalances
- Reversal of sleep-wake pattern or insomnia
- Blood tests reveal leukocytosis and impaired liver function

- Death may occur due to cardiovascular collapse, infection, hyperthermia or self-inflicted injury

### 3. *Alcohol-induced amnestic disorders*

Chronic alcohol abuse associated with thiamine (vitamin 'B') deficiency is the most frequent cause of amnestic disorders. This condition is divided into:

- a) Wernicke's syndrome: This is characterized by prominent cerebellar ataxia, palsy of the 6th cranial nerve, peripheral neuropathy and mental confusion.
- b) Korsakoff's syndrome: The prominent symptom in Korsakoff's syndrome is gross memory disturbance. Other symptoms include:
  - Disorientation
  - Confusion
  - Confabulation
  - Poor attention span and distractibility
  - Impairment of insight

### 4. *Alcohol-induced psychiatric disorders*

- a) Alcohol-induced dementia: It is a long term complication of alcohol abuse, characterized by global decrease in cognitive functioning (decreased intellectual functioning and memory). This disorder tends to improve with abstinence, but most of the patients may have permanent disabilities.
- b) Alcohol-induced mood disorders: Excess drinking may induce persistent depression or anxiety
- c) Suicidal behavior: Suicidal rates are higher in alcoholics when compared to non-alcoholics of the same age. The risk factors for suicidal behavior are continued drinking, co-morbid major depression, serious medical illness, unemployment and poor social support.
- d) Alcohol-induced anxiety disorder: Alcohol persons report panic attacks during acute withdrawal, similarly during the first 4 to 6 weeks of abstinence.
- e) Impaired psychosexual function: Erectile dysfunction and delayed ejaculation are common in chronic alcoholics

- f) Pathological jealousy: Excessive drinkers may develop an overvalued idea or delusion that the partner is being unfaithful.
- g) Alcoholic seizures (rum fits): Generalized tonic clonic seizures occur usually within 12-48 hours after a heavy bout of drinking. Sometimes, status epilepticus may be precipitated.
- h) Alcoholic hallucinosis: This is characterized by the presence of hallucinations (auditory) during abstinence, following regular alcohol intake. Recovery occurs within one month.

### Treatment

1. *A full assessment*, including an appraisal of current medical, psychological and social problems.
2. *Goal setting*: Setting up of short-term goals that deal with any accompanying problems in health, marriage, job and social adjustments; long-term goals can be set as treatment progresses, which are concerned with trying to change factors that precipitate or maintain excessive drinking, such as tensions in the family.
3. *Treatment of withdrawal from alcohol*
  - a. *Detoxification*: Detoxification is the treatment for alcohol withdrawal symptoms. The drugs of choice are benzodiazepines. The most commonly used drugs from this class are chlordiazepoxide 80-200 mg/day and diazepam 40-80 mg/day, in divided doses.
  - b. *Others*:
    - For vitamin B deficiency a preparation of vitamin B containing 100 mg of thiamine should be administered parenterally, twice daily for 3 to 5 days. This should be followed by oral administration of vitamin B for at least 6 months.
    - Administration of anticonvulsants as necessary, maintaining fluid and electrolyte balance, strict monitoring of vitals, level of consciousness and orientation. Close observation is essential, especially during the first five days.

4. *Alcohol deterrent therapy:* Deterrent agents are those which are given to desensitize the individual to the effects of alcohol and maintain abstinence. The most commonly used drug is disulfiram (tetraethyl thiuram disulfide) or antabuse.

*Disulfiram:* Disulfiram is used to ensure abstinence in the treatment of alcohol dependence. Its main effect is to produce a rapid and violently unpleasant reaction in a person who ingests even a small amount of alcohol while taking disulfiram.

*Mechanism of action* Disulfiram is an aldehyde dehydrogenase inhibitor that interferes with the metabolism of alcohol and produces a marked increase in blood acetaldehyde levels. The accumulation of acetaldehyde (to a level of 10 times more than that which occurs in the normal metabolism of alcohol) produces a wide array of unpleasant reactions called the disulfiram-ethanol reaction (DER), characterized by nausea, throbbing headache, vomiting, hypotension, flushing, sweating, thirst, dyspnea, tachycardia, chest pain, vertigo, blurred vision and a sense of impending doom associated with severe anxiety. The reaction occurs almost immediately after the ingestion of even one alcoholic drink and may last up to 30 minutes.

*Therapeutic indications* The primary indication for disulfiram use is as an aversive conditioning treatment for alcohol dependence.

*Side-effects* The adverse effects of disulfiram in the absence of alcohol consumption include fatigue, dermatitis, impotence, optic neuritis, mental changes, acute polyneuropathy and hepatic damage.

With alcohol consumption the intensity of the disulfiram-alcohol reactions varies with each patient. In extreme cases it is marked by convulsions, respiratory depression, cardiovascular collapse, myocardial infarction and death.

#### Contraindications

- Pulmonary and cardiovascular disease.
- Disulfiram should be used with caution in patients with nephritis, brain damage, hypothyroidism, diabetes, hepatic disease, seizures, poly-drug dependence or an abnormal electroencephalogram.
- Patients at high risk of alcohol ingestion.

*Dosage* Disulfiram is supplied in tablets of 250 and 500 mg. The usual initial dose is 500 mg/day orally for the first 2 weeks, followed by a maintenance dosage of 250 mg/day. The dosage should not exceed 500 mg/day.

#### Nurse's responsibility

- An informed consent should be taken before starting treatment.
- Ensure that at least 12 hours have elapsed since the last ingestion of alcohol before administering the drug.
- Patient must be instructed that ingestion of even the smallest amount of alcohol brings on a disulfiram-ethanol reaction with all its unpleasant effects ; he should therefore be strictly warned not to take any alcohol whatever.
- The patient should also be warned against ingestion of any alcohol-containing preparations such as cough syrups, drops of any kind, and alcohol-containing foods and sauces. Advise not to use alcohol based aftershave lotions and advise against inhalation of paints, varnishes, etc., containing alcohol. Any topical applications containing alcohol should also be avoided.
- Caution patient against taking CNS depressants or any OTC (over-the-counter) medications during disulfiram therapy.
- Instruct patient to avoid driving or other activities requiring alertness until response to drug is known.
- Patients should be warned that the disulfiram-alcohol reaction may continue for as long as 1 to 2 weeks after the last dose of disulfiram.

- Patients should carry identification cards describing disulfiram-alcohol reaction and listing the name and telephone number of the physician to be called.
  - Emphasize the importance of follow-up visits to the physician to monitor progress in long-term therapy.
5. *Psychological treatment*

*Motivational interviewing:* This involves providing feedback to the patient on the personal risks that alcohol poses, together with a number of options for change.

*Group therapy:* Group therapy enables the patients to observe their own problems mirrored in others and to work out better ways of coping with them.

*Aversive conditioning:* This therapy is based on classical conditioning. In alcoholism the behavior patterns are self-reinforcing and pleasurable, but are maladaptive for reasons outside the control of the client. In this technique the client is exposed to chemically-induced vomiting or shock when he takes alcohol.

*Cognitive therapy:* This involves reduction in alcohol intake by identifying and modifying maladaptive thinking patterns.

*Relapse prevention technique:* This technique helps the patient to identify high-risk relapse factors and develop strategies to deal with them. It also enables the patient to learn methods to cope with cognitive distortions.

*Cue exposure technique:* This technique aims through repeated exposure to desensitize drug abusers to drug effects, and thus improve their ability to remain abstinent.

Other therapies include *assertiveness training, behavior counseling, supportive psychotherapy and individual psychotherapy.*

### **Agencies Concerned with Alcohol-related Problems**

#### ***Alcoholics Anonymous (AA)***

This is a self-help organization founded in the USA by two alcoholic men, Dr. Bob Smith

and Bill Wilson, a stockbroker on the 10th of June, 1935. It has since then spread to many countries in the world. AA considers alcoholism as a physical, mental and spiritual disease, a progressive one, which can be arrested but not cured. Members attend group meetings usually twice a week on a long-term basis. Each member is assigned a support person from whom he may seek help when the temptation to drink occurs. In crisis he can obtain immediate help by telephone. Once sobriety is achieved he is expected to help others.

The organization works on the firm belief that abstinence must be complete. The only requirement for membership is a desire to stop drinking. There is no authority, but only a fellowship of imperfect alcoholics whose strength is formed out of weakness. Their primary purpose is to help each other stay sober and help other alcoholics to achieve sobriety.

#### **"Twelve Steps" of A.A.**

The "Twelve Steps" are the core of the A.A. program of personal recovery from alcoholism. They are not abstract theories; but are based on the trial-and-error experience of early members of A.A. They describe the attitudes and activities that these early members believe were important in helping them to achieve sobriety. Acceptance of the "Twelve Steps" is not mandatory in any sense.

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God, as *we understood Him*, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

#### "Twelve Traditions" of A.A.

The "Twelve Traditions" of A.A. are suggested principles to ensure the survival and growth of the thousands of groups that make up the Fellowship. They are based on the experience of groups themselves during the critical early years of the movement.

The Traditions are important to both oldtimers and newcomers as reminders of the true foundations of A.A. as a society of men and women whose primary concern is to maintain their own sobriety and help others to achieve sobriety:

1. Our common welfare should come first; personal recovery depends upon A.A. unity.
2. For our group purpose there is but one ultimate authority – a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for A.A. membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or A.A. as a whole.
5. Each group has but one primary purpose to carry its message to the alcoholic who still suffers.

6. An A.A. group ought never endorse, finance, or lend the A.A. name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.
7. Every A.A. group ought to be fully self-supporting, declining outside contributions.
8. Alcoholics Anonymous should remain forever non-professional, but our service centers may employ special workers.
9. A.A., as such ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.

#### Al-Anon

Al-Anon is a group started by Mrs. Anne, wife of Dr. Bob to support the spouses of alcoholics.

#### Al-Ateen

Provides support to their teenage children.

#### Hostels

These are intended mainly for those rendered homeless due to alcohol-related problems. They provide rehabilitation and counseling. Usually abstinence is a condition of residence.

[Refer p. 139 and 140 for rehabilitation and nursing management]

## OTHER SUBSTANCE USE DISORDERS

### Drug Addiction in India: UN Report (The Indian Express Feb.1999)

Of the 4 million registered drug addicts in South Asia, 1.25 lakh are in India.

### Distribution:

- Alcohol: 42% (including social drinkers)
- Opium: 20%
- Heroin: 13%
- Cannabis: 6.2%
- Others: 1.8%
- Heroin abusers are now estimated to be around 40,000.
- The majority of drug addicts are aged between 16 and 30 years.
- These drug abusers are mostly unmarried, and from the lower socio-economic strata; 33 percent of them are engaged in antisocial activities.

### Opioid Use Disorders

In the last few decades, the use of opioids has increased markedly world over. India, surrounded on both sides by routes of illicit transport, namely Golden Triangle (Burma, Thailand, Laos) and Golden Crescent (Iran, Afghanistan, Pakistan), is particularly affected. The most important dependence producing derivatives are morphine and heroin.

The commonly abused opioids (narcotics) in our country are heroin (*brown sugar, smack*) and synthetic preparations like pethidine, fortwin (pentazocine) and tidigesic (buprenorphine). The drugs that are injected through needle are heroin, buprenorphine and pentazocine. Though most opiate users had begun chasing (inhaling the smoke or *chasing the dragon*) heroin they gradually shifted to needle use. These injecting drug users have become a high risk group for HIV infection.

### Acute Intoxication

It is characterized by apathy, bradycardia, hypotension, respiratory depression, subnormal temperature and pinpoint pupils. Later delayed reflexes, thready pulse and coma can occur.

### Withdrawal Syndrome

Narcotic withdrawal rarely produces a life-threatening situation. Common symptoms include watery eyes, running nose, yawning, loss of

appetite, irritability, tremors, sweating, cramps, nausea, diarrhea, insomnia, raised body temperature, piloerection and anorexia.

Withdrawal symptoms begin within 12 hours of the last dose, peak in 24 to 36 hours and disappear in 5 to 6 days.

### Complications

- Complications due to illicit drug use: Parkinsonism, peripheral neuropathy, transverse myelitis.
- Complications due to intravenous use: Skin infection, thrombophlebitis, pulmonary embolism, endocarditis, septicemia, AIDS, viral hepatitis and tetanus.
- Involvement in criminal activities.

### Treatment

*Treatment of opioid overdose:* Opioid overdose can be treated with narcotic antagonists, e.g. naloxone, naltrexone

*Detoxification:* Withdrawal symptoms can be managed by methadone, clonidine, naltrexone, buprenorphine, etc.

*Maintenance therapy:* After the detoxification phase is over, the patient is maintained on one of the following regimens:

- Methadone maintenance
- Opioid antagonists
- Psychological methods like individual psychotherapy, behavior therapy, group therapy and family therapy

### Cannabis Use Disorder

Cannabis is derived from hemp plant, *Cannabis sativa*. The dried leaves and flowering tops are often referred to as *ganja* or *marijuana*. The resin of the plant is referred to as *hashish*. *Bhang* is a drink made from cannabis.

Cannabis is either smoked or taken in liquid form.

### Acute Intoxication

Mild intoxication is characterized by mild impairment of consciousness and orientation, tachy-

cardia, a sense of floating in the air, euphoria, dream-like states, 'flashback' phenomena, alteration in psychomotor activity, tremors, photophobia, lacrimation, dry mouth and increased appetite.

Severe intoxication causes perceptual disturbances like depersonalization, derealization, synesthesias and hallucinations.

#### *Withdrawal Symptoms*

They are mostly found in the first 72-96 hours and include increased salivation, hyperthermia, insomnia, decreased appetite, loss of weight and insomnia.

#### *Complications*

- Transient or short-lasting psychiatric disorders such as acute anxiety, paranoid psychosis, hysterical fugue-like states, hypomania, schizophrenia-like state.
- Amotivational syndrome.
- Memory impairment.

#### *Treatment*

- Supportive and symptomatic treatment

#### **Cocaine Use Disorder**

Common street name is 'crack'. It can be administered orally, intranasally by smoking, or parenterally.

#### *Acute Intoxication*

Characterized by pupillary dilatation, tachycardia, hypertension, sweating and nausea and hypomanic picture.

#### *Withdrawal Syndrome*

Agitation, depression, anorexia, fatigue and sleepiness.

#### *Complications*

Acute anxiety reaction, uncontrolled compulsive behavior, seizures, respiratory depression, cardiac arrhythmias.

#### *Treatment*

*Management of intoxication:* Amyl nitrite is an antidote; diazepam or propranolol are also used.

*For withdrawal symptoms:* Antidepressants (imipramine or amitriptyline) and psychotherapy.

#### **Amphetamine Use Disorder**

Amphetamines are powerful CNS stimulants with peripheral sympathomimetic effects. Commonly used amphetamines are pemoline and methylphenidate.

#### *Acute Intoxication*

Characterized by tachycardia, hypertension, cardiac failure, seizures, tremors, hyperpyrexia, pupillary dilation, panic, insomnia, restlessness, irritability, paranoid hallucinatory syndrome and amphetamine-induced psychosis.

#### *Withdrawal Syndrome*

Characterized by depression, apathy, fatigue, hypersomnia or insomnia, agitation and hyperphagia.

#### *Complications*

Seizures, delirium, arrhythmias, aggressive behavior, coma.

#### **LSD Use Disorder (Lysergic acid diethylamide)**

LSD is a powerful hallucinogen, and was first synthesized in 1938. It presumably produces its effects by acting on 5-HT levels in brain. A common pattern of LSD use is 'trip' (occasional use followed by a long period of abstinence).

#### *Intoxication*

Characterized by perceptual changes occurring in clear consciousness, e.g. depersonalization, derealization, illusions, synesthesias (colors are heard, sounds are felt), autonomic hyperactivity, marked anxiety, paranoid ideation and impairment of judgment.

### *Withdrawal Syndrome*

Flashbacks (brief experiences of the hallucinogenic state).

### *Complications*

Anxiety, depression, psychosis or visual hallucinosis.

### *Treatment*

Symptomatic treatment with antianxiety, antidepressant or antipsychotic medications.

### **Barbiturate Use Disorder**

The commonly abused barbiturates are secobarbital, pentobarbital and amobarbital.

### *Intoxication*

Acute intoxication characterized by irritability, lability of mood, disinhibited behavior, slurring of speech, incoordination, attention and memory impairment.

### *Complications*

Intravenous use can lead to skin abscesses, cellulitis, infections, embolism and hypersensitivity reactions.

### *Withdrawal Syndrome*

It is characterized by marked restlessness, tremors, and seizures in severe cases resembling delirium tremens.

### *Treatment*

If the patient is conscious, induction of vomiting and use of activated charcoal can reduce the absorption. Treatment is symptomatic.

### **Inhalants or Volatile Solvent Use Disorder**

The commonly used volatile solvents include petrol, aerosols, thinners, varnish remover and industrial solvents.

### *Intoxication*

Inhalation of a volatile solvent leads to euphoria, excitement, belligerence, slurring of speech,

apathy, impaired judgment and neurological signs.

### *Withdrawal Symptoms*

Anxiety, depression.

### *Complications*

Irreversible damage to the liver and kidneys, peripheral neuropathy, perceptual disturbances and brain damage.

### *Treatment*

Reassurance and diazepam for intoxication.

## **PREVENTION OF SUBSTANCE USE DISORDER**

### *Primary Prevention*

- Reduction of over prescribing by doctors (especially with benzodiazepines and other anxiolytic drugs).
- Identification and treatment of family members who may be contributing to the drug abuse.
- Introduction of social changes is likely to affect drinking patterns in the population as a whole. This is made possible by:
  - Putting up the price of alcohol and alcoholic beverages
  - Controlling or abolishing the advertising of alcoholic drinks
  - Controls on sales (by limiting hours or banning sales in supermarkets)
  - Restricting availability and lessening social deprivation (Governmental measures)
- Other approaches are to strengthen the individual's personal and social skills to increase self-esteem and resistance to peer pressure.
- Health education to college students and the youth about the dangers of drug abuse through the curriculum and mass media. Health education should also include certain specific groups where a substance like alcohol may be culturally accepted. For instance,

certain tribal communities such as the Lambani group manufacture arrack, and its intake is considered normal. Some communities use it in the postnatal period, as alcohol is believed to strengthen the pelvic muscles and also speed up retroversion of the uterus. Such attitudes should be addressed and corrected.

- An overall improvement in the socioeconomic condition of the population.

### *Secondary Prevention*

- Early detection and counseling.
- Brief intervention in primary care (simple advice by a general practitioner plus an educational leaflet).
- Motivational interviewing which involves providing feedback to the patient on the personal risks that alcohol poses, together with a number of options for change.
- A full assessment including an appraisal of current medical, psychological and social problems. Assessment also includes ascertaining whether alcoholism is the primary or secondary problem. For example, a patient with diabetic neuropathy may be using alcohol to numb pain. Alcohol is also used by some to relieve asthmatic symptoms. In such instances, treatment of the medical problem can help to control alcoholism.
- Detoxification with benzodiazepines (diazepam, chlordiazepoxide).

### *Tertiary Prevention*

Specific measures include:

- Alcohol deterrent therapy (Disulfiram or Antabuse).
- Other therapies include assertiveness training (to prevent yielding to peer pressure), teaching coping skills (some take drugs to combat stress), behavior counseling, supportive psychotherapy and individual psychotherapy.
- Agencies concerned with alcohol-related problems: Alcoholics Anonymous (AA), Al-Anon, Al-Ateen, etc.

- Some practical issues under relapse prevention include:
  - Motivation enhancement, including education about health consequences of alcohol use
  - Identifying high-risk situations and developing strategies to deal with them (craving management)
  - Drink refusal skills (assertiveness training)
  - Dealing with faulty cognitions
  - Handling negative mood states
  - Time management
  - Anger control
  - Financial management
  - Developing the work habit
  - Stress management
  - Sleep hygiene
  - Recreation and spirituality
  - Family counseling, to reduce interpersonal conflicts, which may otherwise trigger relapse

## **REHABILITATION**

The aim of rehabilitation of an individual deaddicted from the effects of alcohol/drugs, is to enable him to leave the drug sub-culture and to develop new social contacts. In this, clients first engage in work and social activities in sheltered surroundings and then take greater responsibilities for themselves in conditions increasingly like those of everyday life. Continuing social support is usually required when the person makes the transition to normal work and living.

## **NURSING MANAGEMENT FOR SUBSTANCE USE DISORDER**

### *Nursing Assessment*

1. Recognition of alcohol abuse: The CAGE questionnaire may be adopted for this purpose:
  - C: Have you ever felt you ought to CUT down on your drinking?
  - A: Have people ANNOYED you by criticizing your drinking?
  - G: Have you ever felt GUILTY about your drinking?

**Table 11.1:** Nursing interventions during acute intoxication

| <i>Interventions</i>  | <i>Rationale</i>  |
|---|---|
| (a) Place the client in a room near the nurse's station or where the staff can observe the client closely.                                  | Client's safety is nursing priority.  |
| (b) Monitor the client's sleep pattern; he may need to be restrained at night if confused or if he wanders or attempts to climb out of bed. | - do -  |
| (c) Decrease environmental stimuli (bright lights, television, visitors) when the client is restless, irritable or tremulous.               | Too many stimuli in the environment may increase misperceptions and restlessness. |
| (d) Institute seizure precautions (padded tongue blade and airway at bedside, raised side-rails, etc.)                                      | Seizures can occur during withdrawal, precautions can minimize chances of injury. |
| (e) Reorient the client to person, time, place and situation as needed.   | The client is often confused and needs to be reoriented.                          |
| (f) Talk to the client in simple, direct, concrete language.  | Patient's ability to deal with complex or abstract ideas is limited.              |

- E: Have you ever had a drink first thing in the morning (an EYE-OPENER) to steady your nerves or get rid of a hangover?
- Be suspicious about 'at-risk' factors: Problems in the marriage and family, at work, with finances or with the law; at risk occupations; withdrawal symptoms after admission; alcohol-related physical disorders; repeated accidents; deliberate self-harm.
  - If at-risk factors raise suspicion, the next step is to ask tactful but persistent questions to confirm the diagnosis.
  - Certain clinical signs lead to the suspicion that drugs are being injected: needle tracks and thrombosed veins, wearing garments with long sleeves, etc. IV use should be suspected in any patient who presents with subcutaneous abscesses or hepatitis.
  - Behavioral changes: Absence from school or work, negligence of appearance, minor criminal offences, isolation from former friends and adoption of new friends in a drug culture.
  - Laboratory tests:*
    - Raised Gamma-Glutamyl Transpeptidase (GGT).
    - Raised mean corpuscular volume.

- Blood alcohol concentration.
- Most drugs can be detected in urine, the notable exception being LSD.

#### *Nursing Diagnosis I*

Risk for injury related to hallucinosis, acute intoxication evidenced by confusion, disorientation, inability to identify potentially harmful situations.

*Objective:* Client will not harm self.

*Intervention:* See Table 11.1.

#### *Nursing Diagnosis II*

Altered health maintenance related to inability to identify, manage or seek out help to maintain health, evidenced by various physical symptoms, exhaustion, sleep disturbances, etc.

*Objective:* The client will maintain optimum health status.

*Intervention:* See Table 11.2.

#### *Nursing Diagnosis III*

Ineffective denial related to weak, underdeveloped ego, evidenced by lack of insight, rationa-

**Table 11.2:** Nursing interventions to improve health status of alcoholics

| <i>Interventions</i>  | <i>Rationale</i>  |
|---|---|
| (a) Monitor the client's health status. Administer medications as prescribed by physician. Observe the client for any behavioral changes and inform physician when necessary. | To evaluate the client's progress accurately.   |
| (b) Maintain fluid and electrolyte balance.   | Patients with alcohol abuse problems are at high risk for fluid and electrolyte imbalances.   |
| (c) Provide food or nourishing fluids as soon as the client can tolerate eating (bland food usually is tolerated best at first).  | Many patients who use alcohol heavily experience gastritis, anorexia and so forth. Therefore bland foods are tolerated most easily. It is important to re-establish nutritional intake as soon as possible. |
| (d) Ensure that amount of protein in the diet is correct for individual patient condition.  | Diseased liver may be incapable of properly metabolizing proteins, resulting in an accumulation of ammonia in the blood that circulates to the brain and can result in altered consciousness.               |
| (e) Provide small frequent feedings of patient's favorite foods. Supplement with vitamins and minerals.   | To correct malnutrition.  |
| (f) Assist the client in self-care activities; it may be necessary to provide complete physical care, depending on the severity of the client's withdrawal.                   | The level of client independency is determined by the severity of withdrawal symptoms. The client's needs should be met with the greatest degree of independence he can attain.                             |

**Table 11.3:** Nursing interventions to improve adaptive behaviour

| <i>Interventions</i>  | <i>Rationale</i>  |
|---|---|
| (a) Develop trust, convey an attitude of acceptance. Ensure that patient understands it is not him but his behavior that is unacceptable.                           | Unconditional acceptance promotes dignity and self-worth.   |
| (b) Identify recent maladaptive behaviors or situations that have occurred in the patient's life and discuss how use of drugs/alcohol may be a contributing factor. | The first step in decreasing denial and rationalization is for patient to see the relationship between substance use and personal problems. |
| (c) Do not allow patient to rationalize or blame others for behaviors associated with substance use.  | This only serves to prolong the denial.   |
| (d) Provide positive reinforcement when the client shows insight into his behavior.   | Enhances repetition of desirable behavior.  |

**Table 11.4:** Nursing interventions to improve adaptive coping skills among alcoholics

| Interventions   | Rationale  |
|---|--|
| (a) Encourage client to explore options available to deal with stress, rather than resorting to substance use. Practice these techniques.                                   | To develop desirable ways of coping with stress.   |
| (b) Give positive reinforcement for ability to delay gratification and respond to stress with adaptive coping strategies.   | Because of weak ego, patient needs a lot of positive feedback to enhance self-esteem.  |
| (c) Teach client and family that alcoholism is a disease that requires long-term treatment and followup. Refer to AA, Al-Anon and other support groups as indicated.        | Family and significant others are also affected by the client's substance use and need help.   |
| (d) Teach the client about the prevention of HIV transmission.  | Patients with alcohol/drug use may involve in high risk behaviors which increase the risk of HIV transmission. Patient will not feel left alone to deal with his problems.                                 |
| (e) Maintain frequent contact with the client, even if it is only by a brief telephone call.  | The client may be able to see the relatedness of the event or a pattern of behavior while discussing the situation. Anticipatory planning may prepare the client to avoid similar circumstances in future. |
| (f) If drinking occurs, discuss the events that led to the incident with the patient in a non-judgmental manner. Discuss ways to avoid similar circumstances in the future. | Scheduled events provide the patient with something to look forward to.  |
| (g) Assist the patient to plan weekly, or even daily, schedules of purposeful activities, such as appointments, talking walks, etc.   |  |

lization of problems, blaming others, failure to accept responsibility for his behavior.

**Objective:** Patient will understand the effect of his behavior on others and verbalize acceptance of responsibility and desire for change.

**Intervention:** See Table 11.3.

#### Nursing Diagnosis IV

Ineffective individual coping related to impairment of adaptive behavior and problem-solving abilities, evidenced by use of substances as coping mechanisms.

**Objective:** Patient will be able to use adaptive coping mechanisms, instead of abusing drugs/alcohol, in response to stress.

**Intervention:** See Table 11.4.

#### Evaluation

The following questions can be useful in evaluating the nursing care:

- Has detoxification occurred without complications?
- Has a correlation been made between personal problems and the use of substances?
- Does he accept responsibility for own behavior?

#### REVIEW QUESTIONS

- Drug addiction (Oct 2000)
- Drugs commonly used for addiction (Nov 2003)
- Drug abuse (Apr 2002, Apr 2004), dependence (Nov 2003), tolerance and withdrawal state

- What are the dependency producing drugs (Oct 2000)
- Etiology of substance use (Nov 1999)
- Complications of alcohol dependence
- Delirium tremens (Nov 1999, Oct 2005)
- Korsakoff's syndrome (Apr 2006)
- Prevention of alcohol abuse (Feb 2000)
- Treatment of alcohol dependence
- Alcohol anonymous (Oct 2000, Oct 2005, Apr 2006)
- Opioid use disorders
- Prevention of drug abuse (Feb 2000)
- Nursing management for substance use disorder (Oct 2000, Nov 2001, Nov 2002, Nov 2003, Oct 2004)
- Out line rehabilitation program for an alcoholic patient who is on anatabuse therapy (Nov 2003)
- Esperol (Apr 2002)

# 12

## *Disorders of Adult Personality and Behavior*

### PERSONALITY DISORDER

- Definition (ICD9)
- Incidence
- Classification
- Clinical features of abnormal personalities
- Etiology
- Treatment
- Nursing Intervention

### SEXUAL DISORDERS

- Classification
- Nursing Intervention

### **PERSONALITY DISORDER**

The term personality refers to enduring qualities of an individual that are shown in his ways of behaving in a wide variety of circumstances. Personality disorders result when personality traits become abnormal, i.e. become inflexible and maladaptive and cause significant social or occupational impairment or significant subjective distress.

In ICD10, they are listed under the section on Disorders of Adult Personality and Behavior (F6).

#### **Definition (ICD9)**

The definition of abnormal personality given by ICD9 is as follows:

An abnormal personality is one in which there are "deeply ingrained maladaptive patterns of behavior recognizable by the time of adolescence or earlier and continuing through most of adult life. Because of this, the patient suffers or others have to suffer, and there is an adverse affect on the individual or on society."

#### **Incidence**

The prevalence of personality disorders in the general population is 5 to 10%. Occurrence of

mixed personality disorders is more common than a single personality disorder in an individual.

#### **Classification**

##### **A. ICD10**

- Paranoid personality disorder
- Schizoid (schizotypal) personality disorder
- Dissocial personality disorder
- Emotionally unstable (impulsive and borderline type) personality disorder
- Histrionic personality disorder
- Anankastic (obsessive-compulsive personality disorder)
- Anxious (avoidant) personality disorder
- Dependent personality disorder
- Other disorders

##### **B. DSMIV**

In DSMIV, personality disorders are coded on axis II and have been divided into three clusters:

- a. Cluster A (odd and eccentric): paranoid, schizoid, schizotypal personality disorders
- b. Cluster B (dramatic, emotional and erratic): antisocial, histrionic, narcissistic personality disorders
- c. Cluster C (anxious and fearful): avoidant, dependent and obsessive-compulsive personality disorders

#### **Clinical Features of Abnormal Personalities**

##### **a. Paranoid Personality Disorder**

- Suspicious
- Mistrustful
- Sensitive

- Argumentative
  - Stubborn
  - Self-important
- b. *Schizoid Personality Disorder*
- Emotionally cold
  - Aloof
  - Detached
  - Humourless
  - Introspective
- c. *Schizotypal Disorder*
- Inappropriate affect
  - Odd beliefs or magical thinking
  - Social withdrawal
  - Odd, eccentric or peculiar behavior
- d. *Antisocial (Dissocial) Personality Disorder (Sociopath, Psychopath)*
- Failure to sustain relationships
  - Disregard for the feelings of others
  - Impulsive actions
  - Low tolerance to frustration
  - Tendency to cause violence
  - Lack of guilt
  - Failure to learn from experience
- e. *Histrionic Personality Disorder*
- This disorder is more common in females
- Dramatic emotionality (Emotional blackmail, angry scenes, demonstrative suicide attempts, etc.)
  - Craving for novelty and excitement
  - Shallow and labile affectivity
  - Attention-seeking behavior
  - Over concern with physical attractiveness
- f. *Narcissistic Personality Disorder*
- Inflated sense of self-importance
  - Attention-seeking, dramatic behavior
  - Unable to face criticism
  - Lack of empathy
  - Exploitative behavior
- j. *Borderline Personality*
- Unstable relationships
  - Impulsive behavior
  - Variable moods
  - Lack of control on anger
  - Recurrent suicidal threats or behavior
  - Uncertainty about personal identity
  - Chronic feelings of emptiness
  - Efforts to avoid abandonment
  - Transient stress-related paranoid or dissociative symptoms
- h. *Anxious (Avoidant) Personality Disorder*
- Persistent feeling of tension and apprehension
  - Inferiority complex
  - Fear of criticism, disapproval or rejection
  - Unwillingness to become involved with people
  - Excessive preoccupation with being criticized or rejected in social situations
- i. *Dependent Personality*
- Subordination of one's own needs
  - Unwillingness to make even reasonable demands on other people
  - Inability to take decision
  - Feeling uncomfortable or helpless when alone
- j. *Obsessive-compulsive (anankastic) Personality Disorder*
- Feeling of excessive doubt and caution
  - Preoccupation with details, rules, lists, order or schedule
  - Perfectionism
  - Rigidity and stubbornness
  - High standards.
- Etiology**
- A. *Heredity factors:* Chromosomal abnormality or genetic predisposition can be responsible for a psychopathic personality.
  - B. *Relation of personality disorder to mental disorder:* For example, schizoid personalities are

considered to be partial expressions of schizophrenia.

C. *Personality disorder and upbringing:* e.g. disturbed parent-child relationships.

D. *Other causes:*

- Maternal deprivation, especially in *antisocial* personality.
- *Borderline* personalities are more likely to report physical and sexual abuse in childhood.
- *Histrionic* personality is said to occur as a result of failure to resolve oedipal complex and excessive use of repression as a mechanism of defense.
- *Dependent* personality may be due to fixation in the oral stage of development.
- *Paranoid* personality is due to absence of trust, which results from lack of parental affection in childhood and persistent rejection by parents leading to low self-esteem.

### Treatment

Personality disorder is often difficult to treat. Drug treatment has a very limited role and may be used if associated mental illness like depression or psychosis is present. Individual and group psychotherapy, therapeutic community and behavioral therapy may be beneficial. Manipulation of the social environment can be tried.

### Nursing Intervention

#### A. *Antisocial Personality Disorder*

- Convey an accepting attitude towards the patient. Be honest, keep all promises and convey the message that it is not him but his behavior which is unacceptable.
- Maintain low level of stimuli in the environment to decrease agitation and aggressive behavior; remove all dangerous objects from the environment.
- Help the patient to identify the true object of his hostility and encourage him to gradually verbalize hostile feelings. This may help him to come to terms with unresolved issues.

- Explore with patient alternative ways of handling frustration to relieve pent-up tensions (e.g. large motor skills that channel hostile energy into socially acceptable behavior).
- Staff should maintain a calm attitude. Have sufficient staff available to present a show of strength to patient if necessary. It also provides some physical security for the staff.
- Administer tranquilizing medications as prescribed.
- Mechanical restraints may be necessary if the client is not calmed by 'talking down' or by medication.
- Explain consequences if limits are violated. A consequence must involve something of value to the client, and all staff must be consistent in enforcing these limits.
- Provide positive feedback for acceptable behavior which will encourage repetition of desirable behaviors.
- Help client to gain insight into his own behavior. He must understand that certain behaviors will not be tolerated within the society and that severe consequences will be imposed upon those individuals who refuse to comply.
- Talk about his past behaviors. Help him identify ways in which he has exploited others. Encourage him to explore how he would feel if the circumstances were reversed.

#### B. *Borderline Personality Disorder*

- Observe patient's behavior frequently. Do this during routine activities and interaction; avoid appearing watchful and suspicious.
- Secure a verbal contract from patient that he will seek out staff members for help when urge for self-mutilation is felt.
- If self-mutilation occurs, care for patient's wounds in matter-of-fact manner. Do not give positive reinforcement to this behavior by offering sympathy or additional attention. Assign staff on a one-to-one basis if need arises.
- Encourage patient to talk about feelings he was having just prior to this behavior. Act as

a role model for appropriate expression of angry feelings. Give positive reinforcement when attempts to conform are made.

- Set limits on acting out behavior.
- Rotate staff who work with the patient to prevent the patient from developing dependence on particular staff members.
- Explore feelings that relate to fears of abandonment. Help client understand that these fears are causing his clinging and distancing behaviors. Help patient understand how these behaviors interfere with satisfactory relations.

## SEXUAL DISORDERS

In ICD10 gender identity disorders, disorders of sexual preference and sexual development and orientation disorders are listed under Disorders of Adult Personality and Behavior (F6), while sexual dysfunctions are listed under Behavioral Syndromes Associated With Physiological Disturbances and Physical Factors (F5).

### Classification

- Gender identity disorders.
- Psychological and behavioral disorders associated with sexual development and maturation.
- Disorders of sexual preference (paraphilic).
- Sexual dysfunctions.

### Gender Identity Disorders (F6)

In these disorders, the sense of one's masculinity or femininity is disturbed. They include:

- Transsexualism.
  - Gender identity disorder of childhood.
  - Dual-role transvestism.
  - Intersexuality.
- a. *Transsexualism:* In this, there is a persistent and significant sense of discomfort regarding one's anatomic sex and a feeling that it is inappropriate to one's perceived gender. The person will be preoccupied with the wish to get rid of one's genitals and secondary sex characteristics and to adopt the sex characteristics of the other sex.

### Treatment

- Counseling to help the individual reconcile with the anatomic sex.
- Sex change to the desired gender [sex reassignment surgery (SRS)] in selected cases
- b. *Gender identity disorder of childhood:* This is a disorder similar to transsexualism, with a very early age of onset.
- c. *Dual-role transvestism:* It is characterized by wearing clothes of the opposite sex in order to enjoy the temporary experience of membership of the opposite sex but without any desire for permanent sex change.
- d. *Intersexuality:* The patients have gross anatomical or physiological features of the other sex. For example, pseudohermaphroditism, Turner's syndrome, congenital adrenal hypoplasia.

### Psychological and Behavioral Disorders Associated with Sexual Development and Maturation (F6)

#### *Homosexuality*

In this, sexual relationships are maintained between persons of the same sex. Female homosexuals are called as 'lesbians' and male homosexuals are called 'gay.'

### Treatment

- Behavior therapy: aversion therapy, covert sensitization, systematic desensitization.
- Supportive psychotherapy.
- Psychoanalytic psychotherapy

### Disorders of Sexual Preference (ICD10 – F6) or Paraphilias (DSMIV)

In paraphilic sexual arousal occurs persistently and significantly in response to objects, which are not a part of normal sexual arousal. These disorders include:

- a. *Fetishism:* Sexual arousal occurs with a non-living object which is usually intimately associated with the human body. The fetish object may include bras, underpants, shoes, gloves, etc.

- b. *Transvestism*: Sexual arousal occurs by wearing clothes of the opposite sex.
- c. *Sexual sadism*: The person is sexually aroused by physical and psychological humiliation, suffering or injury of the sexual partner.
- d. *Sexual masochism*: Here the person is sexually aroused by physical or psychological humiliation or injury inflicted on self by others.
- e. *Exhibitionism*: In this the person is sexually aroused by the exposure of one's genitalia to an unsuspecting stranger.
- f. *Voyeurism*: This is a persistent or recurrent tendency to observe unsuspecting persons naked (usually of the other sex) and engaged in sexual activity.
- g. *Frotteurism*: This is a persistent or recurrent involvement in the act of touching and rubbing against an unsuspecting, non-consenting person.
- h. *Pedophilia*: It is characterized by persistent or recurrent involvement of an adult in sexual activity with prepubertal children.
- i. *Zoophilia (Bestiality)*: Involving in sexual activity with animals.
- j. *Other paraphilias*: Sexual arousal occurs with urine, feces , enemas, etc.

### Treatment

- Behavior therapy: aversion therapy .
- Psychoanalysis.
- Drug therapy: Antipsychotics have been used for severe aggression associated with paraphilias.

### Sexual Dysfunctions (F5)

Sexual dysfunction is a significant disturbance in the sexual response cycle, which is not due to an underlying organic cause

The common dysfunctions are:

- a. *Frigidity*: Absence of desire for sexual activity.
- b. *Impotence*: This disorder is characterized by an inability to have or sustain penile erection till the completion of satisfactory sexual activity.

- c. *Premature ejaculation*: Ejaculation before the completion of satisfactory sexual activity for both partners.
- d. *Non-organic vaginismus*: An involuntary spasm of lower 1/3rd of vagina, interfering with coitus.
- e. *Non-organic dyspareunia*: Pain in the genital area of either male or female during coitus.

### Treatment

- Psychoanalysis
- Hypnosis
- Group psychotherapy
- Behavior therapy

### Nursing Intervention for Client with Sexual Disorder

- Assess client's sexual history and previous level of satisfaction in sexual relationships; also assess client's perception of the problem.
- Note cultural, social, ethnic, racial and religious factors that may contribute to conflicts regarding variant sexual practices.
- Assess for any medications which might be affecting libido.
- Provide information regarding sexuality and sexual functioning, correct any misconceptions if necessary. Teach patient that sexuality is a normal human response and that it involves complex inter-relationships among one's self-concept, body image, family and cultural influences.
- Both the client and his/her partner may need additional assistance if problems in sexual relationship are severe or remain unresolved.
- Refer for additional counseling or sex therapy if required.
- Assist therapist as necessary in plan of behavior modification to help decrease variant behavior.
- In all cases, an accepting and non-judgmental attitude on the part of the nurse is highly essential for successful resolution of these problems as these are highly sensitive issues and may be causing significant distress to the patient.

**REVIEW QUESTIONS**

- Define abnormal personality
- Classification of personality disorders (Nov 1999)
- Paranoid personality disorder
- Schizoid personality disorder
- Antisocial personality disorder (Feb 2000, Oct 2004)
- Sociopathic reactions (Oct 2005)
- Psychopathic personality (Nov 2003)
- Histrionic personality
- Borderline personality
- Etiology of personality disorders (Feb 2000)
- Nursing management for antisocial personality (Feb 2000)
- Sexual disorder (Nov 2002)
- Classification of sexual disorders (Feb 2000)
- Transsexualism (Oct 2005)
- What is voyeurism (Apr 2004)
- Paraphilias (sexual perversions) (Nov 2003)

# 13

## *Childhood Psychiatric Disorders*

- CLASSIFICATION
- MENTAL RETARDATION
- DISORDERS OF PSYCHOLOGICAL DEVELOPMENT
  - Specific Developmental Disorders of Speech and Language
  - Specific Developmental Disorders of Scholastic Skills
  - Specific Developmental Disorders of Motor Function
  - Pervasive Developmental Disorder—Childhood Autism
- BEHAVIORAL AND EMOTIONAL DISORDERS WITH ONSET USUALLY OCCURRING IN CHILDHOOD AND ADOLESCENCE
  - Hyperkinetic Disorder
  - Conduct Disorders
  - Emotional Disorders With Onset Specific to Childhood
    - Separation Anxiety Disorder of Childhood
    - Phobic Anxiety Disorder of Childhood
    - Social Anxiety Disorder of Childhood
    - Sibling Rivalry Disorder
  - Disorders of Social Functioning With Onset Specific to Childhood and Adolescence
  - Tic Disorders
  - Other Behavioral and Emotional Disorders With Onset Usually Occurring In Childhood and Adolescence
    - Non-Organic Enuresis
    - Non-Organic Encopresis
    - Feeding Disorder of Infancy and Childhood
    - Pica
    - Stereotyped Movement Disorders
    - Stuttering (Stammering)

The field of child psychiatry is new to the twentieth century, and child psychiatric nursing evolved gradually as the therapeutic value of nurses' relationship with children began to be

realized. In 1954 the first graduate program in child psychiatric nursing was opened. Advocates for Child Psychiatric Nursing (ACPN), the professional organization for this nursing specialty was established in 1971, and the first ANA certification of child psychiatric nurses took place in 1979. The ANA's Standards of child and adolescent psychiatric and mental health nursing practice were published in 1985.

The child psychiatric nurse uses a wide range of treatment modalities, including milieu therapy, behavior modification, cognitive behavior therapy, therapeutic play, group and family therapy and pharmacological agents.

Child psychiatric nursing is different from adult psychiatric nursing in the following ways:

- It is seldom that children initiate a consultation with the clinician. Instead, they are brought by adults, usually the parents, who think that some aspect of behavior or development is abnormal.
- The child's stage of development determines whether behavior is normal or abnormal. For instance, bedwetting is normal at the age of 3 years but abnormal when the child is 7. Thus greater attention should be paid to the stage of development of the child and duration of the disorder.
- Children are generally less able to express themselves in words; therefore evidence of disturbance is based more on observations of behavior made by parents, teachers and others.
- The treatment of children makes less use of medications or other methods of individual

treatment. Main emphasis is on changing the attitudes of parents, reassuring and retraining children, working with family and coordinating the efforts of others who can help children especially at school.

## CLASSIFICATION (ICD10)

### Mental retardation (F7)

### Disorders of psychological development (F8)

- Specific developmental disorders of speech and language
- Specific developmental disorders of scholastic skills
- Specific developmental disorders of motor function
- Pervasive developmental disorders

Behavioral and emotional disorders with onset usually occurring in childhood and adolescence (F9)

- Hyperkinetic disorders
- Conduct disorders
- Emotional disorders
  - Separation anxiety disorder of childhood
  - Phobic anxiety disorder of childhood
  - Social anxiety disorder of childhood
  - Sibling rivalry disorder
- Disorders of social functioning
  - Elective mutism
- Tic disorders
- Other behavioral and emotional disorders in childhood and adolescence
  - Non-organic enuresis
  - Non-organic encopresis
  - Feeding disorders of infancy and childhood
  - Stereotyped movement disorders
  - Stuttering

## MENTAL RETARDATION (F7)

### Definition

"Mental retardation refers to significantly sub-average general intellectual functioning resulting in or associated with concurrent impairments in adaptive behavior and manifested during the developmental period" (*American Association on Mental Deficiency, 1983*).

'General intellectual functioning' is defined as the result obtained by the administration of standardized general intelligence tests developed for the purpose, and adopted to the conditions of the region/country.

'Significant subaverage' is defined as an Intelligence Quotient (IQ) of 70 or below on standardized measures of intelligence. The upper limit is intended as a guideline and could be extended to 75 or more, depending on the reliability of the intelligence test used.

'Adaptive behavior' is defined as the degrees with which the individual meets the standards of personal independence and social responsibility expected of his age and cultural group. The expectations of adaptive behavior vary with the chronological age. The deficits in adaptive behavior may be reflected in the following areas:

*During infancy and childhood in:*

- Sensory and motor skill development
- Communication skill (including speech and language)
- Self-help skills
- Socialization

*During childhood and adolescence in:*

- Application of basic academic skill to daily life activities
- Application of appropriate reasoning and judgment in the mastery of the environment
- Social skills.

*During late adolescence in:*

- Vocational and social responsibilities and performance.

'Developmental period' is defined as the period of time between conception and the 18th birthday.

### Epidemiology

About 3% of the world population is estimated to be mentally retarded. In India, 5 out of 1000 children are mentally retarded (*The Indian Express, 13th March 2001*). Mental retardation is more common in boys than girls. With severe and profound mental retardation mortality is high due to associated physical diseases.

### Etiology

#### Genetic Factors

##### Chromosomal abnormalities

- Down's syndrome
- Fragile X syndrome
- Trisomy X syndrome
- Turner's syndrome
- Cat-cry syndrome
- Prader-willi syndrome

##### Metabolic disorders

- Phenylketonuria
- Wilson's disease
- Galactosemia

##### Cranial malformation

- Hydrocephaly
- Microcephaly

##### Gross diseases of brain

- Tuberous sclerosis
- Neurofibromatosis
- Epilepsy

### Prenatal Factors

#### Infections

- Rubella
- Cytomegalovirus
- Syphilis
- Toxoplasmosis, herpes simplex

#### Endocrine disorders

- Hypothyroidism
- Hypoparathyroidism
- Diabetes mellitus

#### Physical damage and disorders

- Injury
- Hypoxia
- Radiation
- Hypertension
- Anemia
- Emphysema

#### Intoxication

- Lead
- Certain drugs
- Substance abuse

#### Placental dysfunction

- Toxemia of pregnancy
- Placenta previa
- Cord prolapse
- Nutritional growth retardation

#### Perinatal Factors

- Birth asphyxia
- Prolonged or difficult birth
- Prematurity (due to complications)
- Kernicterus
- Instrumental delivery (resulting in head injury, intraventricular hemorrhage)

#### Postnatal Factors

- Infections
  - Encephalitis
  - Measles
  - Meningitis
  - Septicemia
- Accidents
- Lead poisoning

#### Environmental and Sociocultural Factors

- Cultural deprivation
- Low socioeconomic status
- Inadequate caretakers
- Child abuse

### Classification

|                             | Intelligence Quotient (IQ) |
|-----------------------------|----------------------------|
| Mild (Educable)             | 50-70                      |
| Moderate (Trainable)        | 35-50                      |
| Severe (Dependent retarded) | 20-35                      |
| Profound (Life support)     | <20                        |

### Behavioral Manifestations

#### Mild Retardation (I.Q. 50-70)

This is commonest type of mental retardation accounting for 85 to 90% of all cases. These individuals have minimum retardation in sensory-motor areas. They often progress upto VI standard in school and can achieve vocational and social self-sufficiency with a little support.

They can develop social and communication skills, but have deficits in cognitive function like poor ability for abstraction and egocentric thinking.

#### *Moderate Retardation (I.Q. 35-50)*

About 10% of mentally retarded come under this group. Communication skills develop much slowly in these individuals. They can be trained to support themselves by performing semiskilled or unskilled work under supervision.

#### *Severe Retardation (I.Q. 20-35)*

Severe mental retardation is often recognized early in life with poor motor development and absent or markedly delayed speech and communication skills. There is a possibility of teaching some skills in ADL skills with long-term consistent behavior modification. But most of them require a great deal of assistance and structured living arrangements.

#### *Profound Retardation (I.Q. < 20)*

This group accounts for 1 to 2 percent of all mentally retarded. The achievement of developmental milestones is markedly delayed. They require constant nursing care and supervision. Associated physical disorders are common.

#### **Diagnosis**

- History collection from parents and caretakers.
- Physical examination.
- Neurological examination.
- Assessing milestones development.
- Investigations
  - urine and blood examination for metabolic disorders
  - culture for cytogenic and biochemical studies
  - amniocentesis in infant chromosomal disorders
  - chorionic villi sampling.
- Hearing and speech evaluation.
- EEG, especially if seizures are present.

- CT scan or MRI brain, e.g. in tuberous sclerosis.
- Thyroid function tests when cretinism is suspected.
- Psychological tests like Stanford Binet Intelligence Scale and Wechsler Intelligence Scale For Children (WISC), for categorizing the child's level of disability.

Through psychological testing the mental age of the child is estimated. The Intelligence Quotient is then determined using the formula:

$$\frac{\text{Mental Age (M.A.)}}{\text{Chronological Age (C.A.)}} \times 100$$

#### **Prognosis**

The prognosis for children with mental retardation has improved and institutional care is no longer recommended. These children are mainstreamed whenever feasible and are taught survival skills. A multidimensional orientation is used when working with these children, considering their physiological, cognitive, social and emotional development.

#### **Prevention**

##### *Primary Prevention*

###### *Preconception*

- Genetic counseling, which is an attempt to determine risks of occurrence or recurrence of specific genetic or chromosomal disorders; parents can then make an informed decision as to the risks of having a retarded child.
- Immunization for maternal rubella.
- Blood tests for marriage licenses can identify the presence of venereal diseases.
- Adequate maternal nutrition can lay a sound metabolic foundation for later childbearing.
- Family planning in terms of size, appropriate spacing, and age of parents can also affect a variety of specific causal agents.

###### *During Gestation*

Two general approaches to prevention are associated with this period:

- a. Prenatal care
- b. Analysis of fetus for possible genetic disorders.

a. Prenatal care

- Adequate nutrition, fetal monitoring and protection from disease.
- Avoidance of teratogenic substances like exposure to radiation and consumption of alcohol and drugs.

b. Analysis of fetus

- By amniocentesis, fetoscopy, fetal biopsy and ultrasound.

*At delivery*

- Delivery conducted by expert doctors and staff, especially in cases of high-risk pregnancy (e.g. maternal conditions of diabetes, hypertension etc).
- Apgar scoring done at 1 and 5 minutes after the birth of the child.
- Close monitoring of mother and child.
- Injection of gamma globulin, which can prevent Rh-negative mothers from developing antibodies that might otherwise affect subsequent children.

*Childhood*

- Proper nutrition throughout the developmental period and particularly during the first 6 months after birth.
- Dietary restrictions for specific metabolic disorders until no longer needed.
- Avoidance of hazards in the child's environment to avert brain injury from causes such as lead poisoning, ingestion of chemicals, or accidents.

*Secondary Prevention*

- Early detection and treatment of preventable disorders. For example, phenylketonuria and hypothyroidism can be effectively treated at an early stage by dietary control or hormone replacement therapy.
- Early recognition of presence of mental retardation. A delay in diagnosis may cause unfortunate delay in rehabilitation.
- Psychiatric treatment for emotional and behavioral difficulties.

*Tertiary Prevention*

This includes rehabilitation in vocational, physical and social areas according to the level of handicap. Rehabilitation is aimed at reducing disability and providing optimal functioning in a child with mental retardation.

**Care and Rehabilitation of the Mentally Retarded**

The main elements in a comprehensive service for mentally retarded individuals and their families include:

- The prevention and early detection of mental handicaps.
- Regular assessment of the mentally retarded person's attainments and disabilities.
- Advice, support, and practical measures for families.
- Provision for education, training, occupation, or work appropriate for each handicapped person.
- Housing and social support to enable self-care.
- Medical, nursing, and other services for those who require them as outpatients, day patients, or inpatients.
- Psychiatric and psychological services.

*General provisions:* The general approach to care is educational and psychosocial. The family doctor and pediatrician are mainly responsible for the early detection and assessment of mental retardation. The team providing continuing health care also includes psychologists, speech therapists, nurses, occupational therapists and physio-therapists.

*The mildly retarded:* A few mildly retarded children require fostering, boarding schools placements or residential care, but usually specialist services are not required. Mildly retarded adults may need help with housing, employment, or with the special problems of old age.

*The severely retarded:* In case of children some require special services throughout their lives, which may include a sitting service, day respite

during school holidays, or overnight stays in a foster family or residential care. In case of adults, provisions are required for work, occupation, housing, adult education, etc. The main principle now guiding the provision of resources is that the retarded person should be given sufficient help to be able to use the usual community services, rather than to provide specialist segregated services.

**Education and training:** The aim is that as many mentally retarded children as possible are educated in ordinary schools either in normal classes or in special classes. There is now an increasing use of more specialist teaching and a variety of innovative procedures for teaching language and other methods of communication. Before leaving school, these children require reassessment and vocational guidance.

#### *Hints for successful skill training:*

- Divide each training activity into small steps and demonstrate.
- Give the mentally retarded person repeated training in each activity.
- Give the training regularly and systematically. Do not let parents get impatient.
- Start the training with what the child already knows and then proceed to the skill that needs to be trained. By this the child will have a feeling of success and achievement.
- Reward his effort even if the child attains near success, by appreciation or with something that he likes.
- Reduce the reward gradually as he masters a skill and takes up another skill for training.
- Use the training materials which are appropriate, attractive and locally available.
- Remember, children learn better from children of the same age. Therefore, try and involve normal children of the same age in training the mentally retarded child, after orienting the normal child appropriately.
- Remember, there is no age limit for training a mentally retarded person.
- Assess the child periodically, preferably once in four or six months.

- Remember, a mentally retarded child learns very slowly. Tell the parents not to be dejected at the slow progress, nor feel threatened by the child's failure.

**Vocational training:** The activities included in vocational training are work preparation, selective placement, post placement and follow up.

For example, MITRA Special School and Vocational Training Center for the Mentally Retarded.

**Help for families:** Help for families is needed from the time that the diagnosis is first made; adequate time must be allowed to explain the prognosis; indicate what help can be provided, and discuss the part that the parents can play in helping their child to achieve full potential.

When the child starts school, the parents should not only be kept informed about his progress, but should feel involved in the planning and provision of care.

Families are likely to need extra help when their child is approaching puberty or leaving school; both day and overnight cares are often required to relieve caregivers and to encourage the retarded person to become more independent.

#### *Stages in parent counseling:*

**Stage 1:** Impart information regarding condition of the mentally retarded child. Avoid giving misleading information or building false hopes in the parents.

**Stage 2:** Help the parents develop right attitude towards their mentally retarded child (to prevent overprotection, rejection, pushing the child too hard). Handle guilty feelings in parents.

**Stage 3:** Create awareness in parents regarding their role in training the child. The parents should be made to realize that training a mentally retarded child does not need complex skills and with repeated training in simple steps, the child can learn.

Parents are taught behavior modification techniques to decrease or eliminate problematic behavior, increase adaptive behavior and develop

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new skills. Some of these techniques include positive reinforcement, shaping, prompting, modeling, extinction procedures etc (Refer Chapter 14, p. 187 and 188 for a detailed description).

Parents should be demonstrated how their training has helped their child to acquire new skills. This will give them a sense of achievement, thus making them more involved in the care.

### *Some questions parents ask*

1. Is mental retardation same as mental illness?

No. Mentally retarded persons are not mentally ill. The mentally retarded persons are just slow in their development.

2. Is mental retardation curable?

No. Mental retardation is a condition which cannot be cured. But timely and appropriate intervention can help the mentally retarded person learn several skills.

3. Can marriage solve the problems of mental retardation?

No. Many people think that after marriage, the mentally retarded person will become active and responsible, or sexual satisfaction will cure the person. That is not so. Marriage will only further complicate the problem. When it is known that a mentally retarded person cannot be totally independent, it will not be possible for him to look after his family.

4. Do mentally retarded persons become normal, as they grow older?

No. The mentally retarded person's mental development is slower than that of a normal person. Therefore, when their actual age increases with time, the mental development does not occur at the same pace to catch up with the actual age.

5. Is mental retardation an infectious disease?

No. Many people think that on allowing normal children to mix, eat or play with mentally retarded children, the normal children also develop mental retardation. This is wrong. Interaction between mentally retarded children and normal children on the other hand, helps in the improvement of mentally retarded children.

6. Is it true that the mentally retarded persons cannot be taught anything?

No. Mentally retarded persons can be taught many things, but they need to be trained systematically. They can perform many jobs under supervision.

7. Is it true that mental retardation is due to karma and hence nothing can be done about it?

No. Believing that mental retardation is due to their karma helps the parents to be free from the feelings of guilt. Parents must be told that whatever may be the cause, training the child will improve his condition. The earlier the training is started, the better the chances of improvement.

*Residential care:* Parents should be supported in caring for their retarded children at home, or if they are too heavy a burden for their parents, the child should be cared for in day care centers, halfway homes, etc.

*Specialist medical services:* Retarded children and adults often have physical handicaps or epilepsy for which continuing medical care is needed.

*Psychiatric services:* Expert psychiatric care is an essential part of a comprehensive community service for the mentally retarded.

## Nursing Management

### *Assessment*

- Assessment of early infant behavior for cognitive disability among high risk children should be closely done (e.g. children born to elderly primiparas, birth trauma, etc.); Early infant behaviors that may indicate a cognitive disability include non-responsiveness to contact, poor eye contact during feeding, slow feeding, diminished spontaneous activity, decreased responsiveness to surroundings, decreased alertness to voice or movement, and irritability.
- Documentation of daily living skills.
- A careful family assessment for information on:
  - the family's response to the child

- presence of other members with impaired cognition in the family
- degree of independence encouraged at home
- stability of the family unit.
- Psychological assessment: This is directed at the interaction between the individual and people who are closely involved in care, and determining the correct needs and wishes for the future. It should examine opportunities for learning new skills, making relationships, and achieving maximum choice about the way of life.

#### *Intervention*

- The long-term goals for these children are highly individualized and are dependent on the level of mental retardation. Parents should be involved in establishing realistic goals for their child. Some of these goals can be:
  - the child dresses himself
  - the child maintains continence of stool and urine
  - the child demonstrates acceptable social behavior
  - the adolescent participates in a structured work program
- Early intervention programs are essential to maximize the children's potential development. This necessitates early recognition and referral. Nurses have an opportunity to evaluate children in the nursery, in the clinic during well-baby health care, in schools, and during acute management. The potential of each child will vary according to the degree of mental retardation. The key for success is that the child's strengths and potential abilities are emphasized rather than deficits.
- The nurse can participate in programs that teach infant stimulation, activities of daily living and independent self-care skills. A successful technique in treatment of the mentally retarded is called operant conditioning. It focuses on changing or modifying the individual's response to the environment

- by reinforcing certain desirable patterns of behavior or eliminating undesirable patterns.
- In addition, learning social skills and adaptive behavior assists the child in building a positive self-image. For older children and adolescents assistance is needed to prepare them for a productive work life.
- Sexuality becomes a major concern, as these children may form emotional attachment to those of the opposite sex and have normal sexual desires. However, their decision-making skills are limited. Teaching contraceptive methods are important to emphasize with both the child and family.
- In all instances it is important for the nurse to maintain a non-threatening approach. Very often these children do not understand why physical assessment, therapeutic approaches and evaluative measures are needed. Proper explanation and relevant information should be given to the parents and their help should be enlisted in bringing out the best out of the child. Close collaboration with all members of the team involved in the care of the child is highly essential for a successful outcome. To a large extent the nurse is responsible for the emotional climate of the setting in which she is employed.

(Also refer 'Care and rehabilitation of the mentally retarded' on p. 154)

## **DISORDERS OF PSYCHOLOGICAL DEVELOPMENT (F8)**

### **Specific Developmental Disorders of Speech and Language**

These are disorders in which normal patterns of language acquisition are disturbed from the early stages of development. The conditions are not directly attributable to neurological or speech mechanism abnormality or mental retardation.

It includes developmental language disorder or dysphasia, developmental articulation disorder or phonological disorder or dyslalia, expressive language disorder, receptive language disorder and other developmental disorders of speech and language.

### Specific Developmental Disorders of Scholastic skills

Specific developmental disorders of scholastic skills are divided further into specific reading disorder, specific spelling disorder and specific arithmetic disorder.

*Specific reading disorders (dyslexia)* should be clearly distinguished from general backwardness in scholastic achievement resulting from low intelligence or inadequate education. It is characterized by a slow acquisition of reading skills, slow reading speed, impaired comprehension, word omissions and distortions and letter reversals.

The main feature of *specific spelling disorder* is significant impairment in development of spelling skills in the absence of a history of specific reading disorder. The ability to spell orally and to write out words correctly are both affected.

*Specific arithmetic disorder* involves deficit in basic computational skills of addition, subtraction, multiplication and division.

### Specific Developmental Disorders of Motor Function

Children with this disorder have delayed motor development, which is below the expected level on the basis of their age and general intelligence. The main feature of this disorder is a serious impairment in the development of motor co-ordination, which results in clumsiness in school work or play.

### Pervasive Developmental Disorder

The term Pervasive Developmental Disorder (PDD) refers to a group of disorders characterized by abnormalities in communication and social interaction and by restricted repetitive activities and interests. These abnormalities occur in a wide range of situations, usually development is abnormal from infancy and most cases are manifest before the age of 5 years.

PDD includes childhood autism, atypical autism, Rett's Syndrome, Asperger's syndrome, childhood disintegrative disorder, and other pervasive developmental disorders.

### Epidemiology

Prevalence is 4-5/10,000 in children under 16 years of age. Male to female ratio is 4 or 5 to 1. The disorder is evenly distributed across all socio-economic classes.

### Childhood Autism

In 1908, Heller from Austria reported 6 cases of a disintegrative psychosis with onset in the 3rd or 4th year of life in children whose previous development was normal. Leo Kanner (1943) identified a relatively homogenous group of children with onset of psychosis in the 1st and 2nd year of life whom he designated early "infantile autism" and "autistic disturbance of affect contact." Lauretta Bender first used the term "childhood schizophrenia" to characterize psychotic children. Now all these terms have been replaced and the condition is currently known as Childhood Autism in ICD10, or Autistic Disorder in DSMIV.

### Etiology

*Genetic factors* The higher concordance in monozygotic than dizygotic twins (36% vs 0%) suggests a genetic factor. Siblings of autistic children show a prevalence of autistic disorder of 2 percent (50 times over expected prevalence).

*Biochemical factors* At least 1/3rd of patients with autistic disorder have elevated plasma serotonin.

*Medical factors* There is an elevated incidence of early developmental problems such as post-natal neurological infections (meningitis, encephalitis), congenital rubella and cytomegalovirus, phenylketonuria and rarely perinatal asphyxia. The other inborn errors of metabolism associated with autism are tuberous sclerosis and neurofibromatosis. About 2 to 5% appear to have Fragile X chromosome syndrome. Neurological abnormalities are present in about one-quarter of cases.

*Perinatal factors* During gestation, maternal bleeding after the first trimester and meconium in the amniotic fluid have been reported in the histories of autistic children. There is also a high incidence of medication usage during pregnancy in the mothers of autistic children.

*Psychodynamic and parenting influences and social environment* Some of the specific causative factors proposed in these theories are parental rejection, child responses to deviant parental personality characteristics, family break-up, family stress, insufficient stimulation and faulty communication patterns (Schreibman and Charlop, 1989).

Kanner (1973) in his studies, described the parents of autistic children as well educated upper class individuals, involved in career and intellectual pursuits, who were aloof, obsessive and emotionally cold. The term "refrigerator parents" was coined to describe their lack of warmth and affectionate behavior.

Mahler and associates (1975) suggested that the autistic child is fixed in the presymbiotic phase of development. In this phase, the child creates a barrier between self and others. The normal symbiotic relationship between mother and child followed by the progression to separation/individualization does not occur. Ego development is inhibited and the child fails to achieve a sense of self.

*Theory-of-mind in autism* Theory-of-mind describes the developmental process whereby the child comes to understand others' minds or to anticipate what others may be thinking, feeling, or intending. Children with autistic disorder are sometimes said to be "mind-blind," in that they lack the ability to put themselves in the place of another person.

*Electrophysiological changes* Brain stem Auditory Evoked Responses (BAERs) of autistic children showed impairment in sensory modulation at brain stem level.

*Neuroanatomical studies* These studies have shown an enlargement of lateral ventricles and cerebellar degeneration.

### Clinical Picture

#### Behavioral characteristics

- Autistic aloofness (unresponsiveness to parent's affectionate behavior, by smiling or cuddling).

- Gaze avoidance or lack of eye-to-eye contact.
- Dislikes being touched or kissed.
- No separation anxiety on being left in an unfamiliar environment with strangers.
- No or abnormal social play. Failure to play with peers and unable to make friends.
- Failure to develop empathy.
- Marked lack of awareness of the existence or feelings of others.
- Anger or fear without apparent reason and absence of fear in the presence of danger.

#### Communication and language

- Gross deficits and deviances in language development.
- No mode of communication such as babbling, facial expression, gestures, mime, etc.
- Absence of imaginative activity such as play acting of adult roles, fantasy characters of animals, lack of interest in imaginative stories.
- Marked abnormality in the production of speech (volume, pitch, stress, rhythm, rate etc).
- Marked abnormalities in the form or content of speech including stereotyped or repetitive use of speech, use of "you" when "I" is meant, idiosyncratic use of phrases.
- Marked impairment in the ability to initiate or sustain a conversation with others despite adequate speech.

#### Activities

- Marked restricted, repertoire of activities and interests.
- Stereotyped body movements e.g. hand flicking or twisting, spinning, head banging, etc.
- Persistent preoccupation with parts of objects (e.g. spinning wheels of toy cars) or attachment to unusual objects.
- Marked distress over changes in trivial aspects of environment.
- Markedly restricted range of interests and a preoccupation with one narrow interest.

#### Other features

- More than half of autistic children have moderate to profound mental retardation, whereas about 25% have mild mental retardation.

- Autistic children are resistant to transition and change.
- Over-responsive or under-responsive to sensory stimuli.
- May have a heightened pain threshold or an altered response to pain.
- Other behavioral problems like hyperkinesis, aggression, temper tantrums, self-injurious behavior, head banging, biting, scratching and hair pulling are common.
- Idiot Savant Syndrome: Inspite of a pervasive or abnormal development of functions, certain functions may remain normal, e.g. calculating ability, prodigious remote memory, musical abilities, etc.
- Absence of hallucinations, delusions, loosening of associations as in schizophrenia.
- Kanner's "Autistic triad"- Kanner said autistic aloofness, speech and language disorder and obsessive desire for sameness constitute a triad characteristic of infantile autism.

#### *Course and Prognosis*

- Autistic disorder has a long course and guarded prognosis.
- About 10 to 20% autistic children begin to improve between 4 and 6 years of age and eventually attend on ordinary school and obtain work.
- 10 to 20% can live at home, but need to attend a special school or training center and cannot work.
- 60% improve little and are unable to lead an independent life, mostly needing long-term residential care.
- Those who improve may continue to show language problem, emotional coldness and odd behavior.

#### *Treatment*

- *Pharmacotherapy* is a valuable treatment for associated symptoms like aggression, temper tantrums, self-injurious behavior, hyperactivity and stereotypic behaviour. Some drugs that have been used are risperidone, serotonin specific reuptake inhibitors, clomipramine

and lithium. Antiepileptic medication is used for generalized seizures.

- *Behavioral methods:* Contingency management may control some of the abnormal behavior of autistic children. The term contingency management refers to a group of procedures based on the principle that, if any behavior persists, certain of its consequences are reinforcing it. If these consequences can be altered, the behavior will change. The parents instructed and supervised by a clinical psychologist often carry out this method at home.

Contingency management has the following stages:

- First the behavior to be changed is defined, and another person (usually a nurse, spouse or parent) is trained to record it; for example, a mother might count the number of times a child with learning difficulties shouts loudly.
- Second, the events that immediately follow (and therefore are presumed to reinforce the behavior) are identified; for example, the parents may pay attention to the child when he shouts, but ignore him at other times.
- Third, reinforcements are devised for alternative behaviors, for example, being approved or earning points by refraining from shouting for an agreed time. Staff or relatives are trained to provide the chosen reinforcements immediately after the desired behavior, and to withhold them at other times.
- As treatment progresses, records are kept of the frequency of the problem behaviors and of the desired behaviors.
- Although treatment is mainly concerned with the consequences of behavior, attention is also given to changing any events that might be provoking the behavior. For example, in a psychiatric ward, the abnormal behavior of one child may be provoked on each occasion by the actions of another child.

- *Special schooling:* Most autistic children require special schooling and older adolescents many need vocational training.
- *Counseling and supportive therapy:* The family of an autistic child needs considerable help to cope with the child's behavior, which is often distressing.
- *Others:* Development of a regular routine, positive reinforcements to teach self-care skills, speech therapy or sign language teaching, behavior techniques to encourage interpersonal interactions.

### Nursing Management

**Assessment** The following factors need to be considered in assessing an autistic child (Lord and Rutter, 1994):

- Cognitive level
- Language ability
- Communication skills, social skills and play and repetitive are other abnormal behavior
- Stage of social development in relation to age, mental age and stage of language development
- Associated medical conditions
- Psychosocial factors

### Intervention

- Work with the child on a one-to-one basis.
- Protect the child when self-mutilative behavior occurs. Devices such as a helmet, padded mittens or arm covers may be used.
- Try to determine if self-mutilative behavior occurs in response to increasing anxiety, and if so, to what the anxiety may be attributed. Intervene with diversion or replacement activities as anxiety level starts to rise. These activities may provide needed feelings of security and substitute for self-mutilative behavior.
- Assign limited number of caregivers to the child. Ensure that warmth, acceptance and availability are conveyed.
- Provide child with familiar objects such as familiar toys or a blanket. Support child's attempts to interact with others.

- Give positive reinforcement for eye contact with something acceptable to the child (e.g. food, familiar object). Gradually replace with social reinforcement (i.e. touch, hugging).
- Anticipate and fulfill the child's needs until communication can be established.
- Slowly encourage him to express his needs verbally. Seek clarification and validation.
- Give positive reinforcement when eye contact is used to convey nonverbal expressions or when the child tries to speak.
- Teach simple self-care skills by using behavior modification techniques.
- Language training plays a big part in teaching autistic children. At first they have to learn the names of things by linking the name with the actual object. When teaching the word 'table' they must see and feel a real table, and lots of different tables, otherwise they may think that table refers to only that particular object. Look at child's face and pronounce simple words. Ask the child to repeat the words. Show picture books and name the objects. Verbs like sitting, walking, running can be acted to show the child what these words mean.
- Autistic children have personal identity disturbance and need to be assisted to recognize separateness during self-care activities, such as dressing and feeding. The child should be helped to name own body parts. This can be facilitated with the use of mirrors, drawings and pictures of himself. Encourage appropriate touching of, and being touched by others.
- The role of the parent is crucial for any intervention with the autistic child ; the parent generally acts as a co-therapist and plays an integral role in treatment. The behavior of their autistic child is often very distressing and parental counseling begins with clarification of the diagnosis and an explanation of the characteristics of the disorder. To effectively participate in the treatment program, the parents must have acknowledged the extent of their child's handicap and be able to work with him at the appropriate developmental level.

### **Atypical Autism**

A pervasive developmental disorder that differs from autism in terms of either age of onset or failure to fulfill diagnostic criteria i.e. disturbance in reciprocal social interactions, communication and restrictive stereotyped behavior. Atypical autism is seen in profoundly retarded individuals.

### **Rett's Syndrome**

A condition of unknown cause, reported only in girls. It is characterized by apparently normal or near-normal early development which is followed by partial or complete loss of acquired hand skills and of speech, together with deceleration in head growth, usually with an onset between 7 and 24 months of age.

### **Asperger's Syndrome**

The condition is characterized by severe and sustained abnormalities of social behavior similar to those of childhood autism with stereotyped and repetitive activities and motor mannerisms such as hand and finger-twisting or whole body movements. It differs from autism in that there is no general delay or retardation of cognitive development or language.

## **BEHAVIORAL AND EMOTIONAL DISORDERS WITH ONSET USUALLY OCCURRING IN CHILDHOOD AND ADOLESCENCE (F9)**

### **Hyperkinetic Disorder**

Hyperkinetic disorder (Attention-Deficit Hyperactivity Disorder or ADHD in DSMIV) is a persistent pattern of inattention and or hyperactivity more frequent and severe than is typical of children at a similar level of development. The syndrome was first described by Heinrich Hoff in 1854.

### **Epidemiology**

A prevalence of 1.7 percent was found among primary school children ( Taylor et al, 1991). ADHD is four times more common in boys than in girls.

### **Etiology**

#### *Biological influences*

#### *Genetic factors*

- There is greater concordance in monozygotic than in dizygotic twins
- Siblings of hyperactive children have about twice the risk of having the disorder as does the general population
- Biological parents of children with the disorder have a higher incidence of ADHD than do adoptive parents

#### *Biochemical theory*

A deficit of dopamine and norepinephrine has been attributed in the overactivity seen in ADHD. This deficit of neurotransmitters is believed to lower the threshold for stimuli input

#### *Pre, peri and postnatal factors*

- Prenatal toxic exposure, prenatal mechanical insult to the fetal nervous system
- Prematurity, fetal distress, precipitated or prolonged labor, perinatal asphyxia and low Apgar scores
- Postnatal infections, CNS abnormalities resulting from trauma, etc

#### *Environmental influences*

- Environmental lead
- Food additives, coloring preservatives and sugar have also been suggested as possible causes of hyperactive behavior but there is no definite evidence

#### *Psychosocial factors*

- Prolonged emotional deprivation
- Stressful psychic events
- Disruption of family equilibrium

#### *Clinical Features*

- Sensitive to stimuli, easily upset by noise, light, temperature and other environmental changes.
- At times the reverse occurs and the children are flaccid and limp, sleep more and the growth and development is slow in the first month of life.

- More commonly active in crib, sleep little.
- General coordination deficit.
- Short attention span, easily distractable.
- Failure to finish tasks.
- Impulsivity.
- Memory and thinking deficits .
- Specific learning disabilities

#### *In school*

- Often fidgets with hands or feet or squirms in seat.
- Answers only the first two questions ; often blurts out answers to questions before they have been completed.
- Unable to wait to be called on in school and may respond before everyone else.
- Has difficulty awaiting turn in games or group situations.
- Often loses things necessary for tasks or activities at school.

#### *Home*

- Explosive or irritable.
- Emotionally labile and easily set off to laughter or tears.
- Mood is unpredictable.
- Impulsiveness and an inability to delay gratification.
- Often talks excessively.
- Often engages in physically dangerous activities without considering possible consequences (for example, runs into street without looking).

#### *Diagnosis*

- Detailed prenatal history and early developmental history.
- Direct observation, teacher's school report (often the most reliable), parent's report

#### *Treatment*

##### *Pharmacotherapy*

- CNS stimulants: Dextroamphetamine, methylphenidate, pemoline
- Tricyclic antidepressants
- Antipsychotics

- Serotonin specific re-uptake inhibitors
- Clonidine

##### *Psychological therapies*

- Behavior modification techniques
- Cognitive behavior therapy
- Social skills training

#### *Nursing Intervention*

- Develop a trusting relationship with the child. Convey acceptance of the child separate from the unacceptable behavior.
- Ensure that patient has a safe environment. Remove objects from immediate area in which patient could injure self due to random hyperactive movements. Identify deliberate behaviors that put the child at risk for injury. Institute consequences for repetition of this behavior. Provide supervision for potentially dangerous situations.
- Since there is non-compliance with task expectations, provide an environment that is as free of distractions as possible.
- Ensure the child's attention by calling his name and establishing eye contact, before giving instructions.
- Ask the patient to repeat instructions before beginning a task.
- Establish goals that allow patient to complete a part of the task, rewarding each step completion with a break for physical activity.
- Provide assistance on a one-to-one basis, beginning with simple concrete instructions.
- Gradually decrease the amount of assistance given to task performance, while assuring the patient that assistance is still available if deemed necessary.
- Offer recognition of successful attempts and positive reinforcement for attempts made. Give immediate positive feedback for acceptable behavior.
- Provide quiet environment, self-contained classrooms, and small group activities. Avoid over stimulating places such as cinema halls, bus stops and other crowded places.

- Assess parenting skill level, considering intellectual, emotional and physical strengths and limitations. Be sensitive to their needs as there is often exhaustion of parental resources due to prolonged coping with a disruptive child.
- Provide information and materials related to the child's disorder and effective parenting techniques. Give instructional materials in written and verbal form with step-by-step explanations.
- Explain and demonstrate positive parenting techniques to parents or caregivers, such as time-in for good behavior, or being vigilant in identifying the child's behavior and responding positively to that behavior.
- Educate child and family on the use of psycho-stimulants and anticipated behavioral response.
- Coordinate overall treatment plan with schools, collateral personnel, the child and the family.

### **Conduct Disorders**

Conduct disorders are characterized by a persistent and significant pattern of conduct in which the basic rights of others are violated or rules of society are not followed. The diagnosis is only made when the conduct is far in excess of the routine mischief of children and adolescents. The onset occurs much before 18 years of age, usually even before puberty. The disorder is much more (about 5 to 10 times) common in boys.

### **Etiology**

*Genetic factors* Studies with monozygotic and dizygotic twins as well as with non-twin siblings have revealed a significantly higher number of conduct disorders among those whose family members are affected with the disorder (Baum, 1989). Alcoholism and personality disorder in the father is reported to be strongly associated with conduct disorders.

*Biochemical factors* Various studies have reported a possible correlation between elevated plasma levels of testosterone and aggressive behaviors.

*Organic factors* Children with brain damage and epilepsy are more prone to conduct disorders.

### *Psychosocial factors*

- Parental rejection.
- Inconsistent management with harsh discipline.
- Frequent shifting of parental figures.
- Large family size.
- Absent father.
- Parents with antisocial personality disorder or alcohol dependence.
- Parental permissiveness.
- Marital conflict and divorce in parents.
- Associations with delinquent subgroups.
- Inadequate/inappropriate communication patterns in the family.

### *Clinical Features*

- Frequent lying.
- Stealing or robbery.
- Running away from home and school.
- Deliberate fire-setting.
- Breaking someone else's house articles, car, etc.
- Deliberately destroying other's property.
- Cruelty towards other people and animals.
- Physical violence like rape, assaultive behavior and use of weapons, etc.
- In addition to the typical symptoms of conduct disorder, secondary complications often develop like, drug abuse and dependence, unwanted pregnancies, syphilis, AIDS, criminal record, suicidal and homicidal behavior.

### *Treatment*

The treatment is difficult. The most common mode of management is placement in a corrective institution. Behavioral, educational and psychotherapeutic measures are employed for changing the behavior.

Drug treatment may be indicated in the presence of epilepsy (anticonvulsants), hyperactivity (stimulant medication), impulse control disorder and episodic aggressive behavior (lithium, carbamazepine) and psychotic symptoms (antipsychotics).

*Nursing Intervention*

- The nurse should bear in mind that there is always the risk of violence in these children. She should therefore observe the child's behavior frequently during routine activities and interactions. She should be aware of behavior that indicates a rise in agitation.
- Redirect violent behavior with physical outlets for suppression of anger and frustration.
- Ensure that a sufficient number of staff is available to indicate a show of strength if necessary. Administer tranquilizing medication as prescribed. Use of mechanical restraints or isolation should be used only if the situation cannot be controlled by less restrictive means.
- Explain to the client the correlation between feelings of inadequacy and the need for acceptance from others, and how these feelings provoke aggression or defensive behavior such as blaming others for own faulty behavior. Practice more appropriate responses through role play.
- Set limits on manipulative behavior, and identify the consequences of manipulative behavior. Administer the consequences matter-of-factly and in a non-threatening manner if such behavior occurs.
- Provide immediate positive feedback for acceptable behavior.
- Encourage the child to maintain a log book and make daily entries of his behavior. The entry should consist of a brief statement of an incident when the client was angry or disagreed with another person, what the client thought about the incident afterwards (in his own words), what the client thought about doing, and what he actually did, and the outcome. This provides opportunity for the child to identify his predominant patterns of thinking and behaving in different situations, and recognize new and acceptable ways of responding in situations which provoke such behaviors.
- Review the log with the client before discharge. Provide feedback regarding improved beha-

vioral responses and areas where continued work is needed. Encourage client to continue the log after discharge.

- Social skills training: Some views of aggression emphasize the aggressive child's limited repertoire of cognitive and behavioral skills related to successful peer and adult interaction. This perspective has led to social skills training programs in the context of individual child or family therapy. The key steps for teaching social skills are:
  - presenting the target skill to the child by describing it and discussing when it is relevant;
  - demonstrating the skill by modeling;
  - asking the child to rehearse the skill and providing feedback;
  - role playing example situations that call for use of the skill; and
  - giving the child an assignment involving practice of the skill in real life situations outside the clinical setting
- Guidance and support for parents: In parent training programs, the nurse should emphasize to the parents that reconnecting with their children as positive, nurturing caregivers, comes first. However, management of difficult behavior is a key component in the program, and certain guidelines for discipline include:
  - Develop disciplinary alternatives (such as time out or removal of privileges) to spanking.
  - Spend scheduled time with your child that would foster a more positive relationship with him.
  - Agree on the rules about behavior and consequences, make them clear and stick with them.
  - Don't give a direction unless you are willing to make sure it is followed.Encourage parents to verbalize feelings of guilt and helplessness in dealing with the child. Involve siblings in family discussions and planning for more effective family interactions.
- Working with the school: Aggressive children often display problems across settings, includ-

ding school, or even only in a particular classroom. The nurse should emphasize on close collaboration between parents and school personnel likely to come into contact with the child (principal, assistant principal, guidance counselors, school psychologists, etc.). Children who see their parents and teachers working together find it easier to control their behavior in home and in school.

Truancy requires separate consideration. Pressure should be brought upon the child to return to school, and if possible, the support of the family should be enlisted. At the same time an attempt should be made to resolve educational or other problems at school. In all this, it is essential to maintain good communication between the nurse, parents and teachers.

### **Juvenile Delinquency**

According to Dr. Sethna, Juvenile delinquency involves wrongdoing by a child or a young person who is under an age specified by the law of the place concerned.

From the legal point of view, a juvenile delinquent is a person who is below 16 years of age (18 years, in case of a girl) who indulges in antisocial activity.

Recently there was a clarification made by the Supreme Court in the existing Juvenile Justice Act that a regular court would try a juvenile if he is arrested after crossing the age of 16 though he might have committed the crime when he was under the age of 16 (The Hindu, 15th May 2000).

### **Causes**

#### *Social causes*

- Defects of the family, like broken families, uncaring attitude of parents, bad conduct of parent, etc.
- Defects of the school, like harsh punishment by teachers, weakness in some subjects, a level of education that is above the child's capacity.
- Children living in crime-dominated areas
- Absent or defective recreation
- War and post-war conditions

*Psychological causes* Personality characteristics, (emotional instability, immaturity), emotional insecurity and mental illness.

*Economic causes* Poverty, leading to stealing, prostitution and other antisocial activities to satisfy unfulfilled desires.

### **Reformatory Measures**

- Probation, where the juvenile delinquent is kept under the supervision of a probation officer, whose job is to help him get established in normal life.
- Institutions like reformatory schools, remand homes, certified schools, auxiliary homes. These institutions provide for all-round progress of the delinquent.
- Psychological therapies like play therapy, finger-painting, psychodrama.
- Governmental measures: The Children's Act of 1977 under which remand homes and borstal schools were made available; vocational training and follow-up services. Under the Care Program sponsored by the Central Government, 5 borstal schools, 15 boy's clubs and 5 probation hostels have been established.

### **Separation Anxiety Disorder**

In these disorders there is excessive anxiety concerning separation from those individuals to whom the child is attached.

### **Clinical Features**

- An unrealistic worry about possible harm befalling major attachment figures or fear that they will leave and not return.
- Persistent reluctance or refusal to go to sleep, without being near or next to a major attachment figure.
- Persistent inappropriate fear of being alone.
- Repeated nightmares.
- Repeated occurrence of physical symptoms e.g. nausea, stomachache, headache, etc., on

occasions that involve separation from a major attachment figure, such as leaving home to go to school.

- Excessive tantrums, crying and apathy immediately following separation from a major attachment figure.

#### *Treatment*

*Individual counseling* This is often useful to give the child an opportunity to understand the basis for anxiety and also to teach the child some strategies for anxiety management.

*Parental counseling* Parental counseling is needed when there is evidence that they are over-anxious or over-protective about the child. They should be persuaded to allow the child more autonomy.

*Family therapy* It is often needed when the child's disorder appears to be related to the family system. Treatment is designed to promote healthy functioning of the family system.

*Pharmacological management* Anxiolytic drugs such as diazepam may be needed occasionally when anxiety is extremely severe, but they should be used for short periods only.

#### **Phobic Anxiety Disorder**

Minor phobic symptoms are common in childhood and usually concern animals, insects, darkness, school and death. The prevalence of more severe phobias varies with age. In most cases, all fears decline by early teenage years.

#### *Treatment*

Most childhood phobias improve without specific treatment, provided the parents adopt a firm and reassuring approach. For phobias that do not improve, behavioral treatment combined with reassurance and support are most helpful. Systematic desensitization (gradual introduction of the phobic object or situation while the subject is in a state of relaxation), is an established

treatment. Other methods are implosion or flooding which involves persuading the child to remain in the feared situation at maximum intensity from the start (the reverse of desensitization).

#### **Social Anxiety Disorder**

Children with this disorder show a persistent or recurrent fear and avoidance of strangers which interferes with social functioning. Treatment includes simple behavioral methods, combined with reassurance and support.

#### **Sibling Rivalry Disorder**

Sibling rivalry/jealousy may be shown by marked competition with siblings for the attention and affection of parents, associated with unusual pattern of negative feelings. Onset is during the months following the birth of the younger sibling. In extreme cases there is over-hostility, physical trauma towards and undermining of the sibling, regression with loss of previously acquired skills (such as bowel and bladder control) and a tendency to babyish behavior. There is an increase in oppositional behavior with the parents, temper tantrums, and dysphoria exhibited in the form of anxiety, misery or social withdrawal.

#### *Management*

- Parents should be helped to divide their attention appropriately between the two children.
- Help the older child feel valued. At the same time, limits should be set as appropriate.
- Preventive interventions such as preparing the child mentally for the arrival of the sibling during pregnancy itself, and involving him in the care of the sibling.

#### **Elective Mutism**

This condition is characterized by a marked, emotionally determined selectivity in speaking such that the child demonstrates his language competence in some situations, but fails to speak in other situations. Most typically the child speaks at home or with close friends, and is mute at school or with strangers.

### **Management**

Management includes a combination of behavioral and family therapy techniques to promote communication and the use of speech. Individual psychotherapy may also help.

### **Tic Disorders**

Tic is an abnormal involuntary movement, which occurs suddenly, repetitively, rapidly and is purposeless in nature. It is of two types:

1. Motor tics, characterized by repetitive motor movements.
2. Vocal tics, characterized by repetitive vocalizations.

Tic disorders can be either transient or chronic. A special type of chronic tic disorder is Gilles de la Tourette's syndrome or Tourette's disorder. This is characterized by: multiple motor and vocal tics, with duration of more than 1 year. Onset is usually before 11 years of age and almost always before 21 years of age.

The disorder is more common (about 3 times) in males and has a prevalence rate of about 0.5 per 1000.

### **Motor Tics**

Motor tics can be simple or complex.

#### **Simple Motor Tics**

These may include eye blinking, grimacing, shrugging of shoulders, tongue protrusion.

#### **Complex Motor Tics**

These are facial gestures, stamping, jumping, hitting self, squatting, twirling, echokinesis (repetition of observed acts), and copropraxia (obscene acts).

Motor tics are often the earliest to appear, beginning in the head region and progressing downwards. These are followed by vocal tics.

### **Vocal Tics**

Vocal tics also can be simple or complex.

#### **Simple Vocal Tics**

Simple vocal tics include coughing, barking, throat clearing, sniffing, and clicking.

#### **Complex Vocal Tics**

These include echolalia (repetition of heard phrases), palilalia (repetition of heard words) coprolalia (use of obscene words), and mental coprolalia (thinking of obscene words).

*Etiology of Tourette's syndrome* The etiology of Tourette's syndrome is not known but the presence of learning difficulties, neurological soft signs, hyperactivity, abnormal EEG record, abnormal evoked potentials and abnormal CT brain findings in some patients points towards a biological basis. There is some evidence to suggest that Tourette's syndrome may be inherited as autosomal dominant disorder with variable penetrance.

*Treatment* Pharmacotherapy is the preferred mode of treatment. The drug of choice is haloperidol. In resistant cases or in case of severe side effects, pimozide or clonidine can be used. Behavior therapy may be used sometimes, as an adjunct.

### **Non-organic Enureses**

It is a disorder characterized by involuntary voiding of urine by day and/or night which is abnormal in relation to the individuals mental age and which is not a consequence of a lack of bladder control due to any neurological disorder, epileptic attacks or any structural abnormality of urinary tract. Enuresis would not ordinarily be diagnosed in a child under the age of 5 years or with a mental age less than 4 years.

In most cases, enuresis is primary (the child has never attained bladder control). Sometimes it may be secondary (enuresis starting after the child achieved continence for a certain period of time).

**Factors Associated with Enuresis**

- Faulty training: If toilet training is started too early, and especially if coercive, produces confusion and resentment rather than compliance. Also, if it is begun too late, loss of bladder control can result.
- Emotional disturbances: Emotional problems or conflicts can manifest in the form of disturbed bladder control. These conflicts may be due to such factors like dominating parents, harsh punishments and other problems in the family, causing the child to feel neglected and isolated. As the children grow older, they become sensitive about their habit of bed-wetting. They develop feelings of inferiority and a sense of being different from other children, which aggravates the problem even further.
- Physical diseases and anatomic defects (e.g. congenital anomalies of the genitourinary tract, diseases involving the central nervous system) are relatively rare causes for enuresis.

**Management**

- Exclude any physical basis for enuresis by history, examination and if necessary, investigation of the renal tract.
- Explain the parents and child about the maturational basis of the problem and the likelihood of spontaneous improvement.
- The child should be encouraged to keep a diary of the pattern of night time dryness/wetness, which can be done with a star chart. This consists of a record of dry nights with a star placed on the sheet for each dry night. The star chart system has 3 functions:
  - it provides an accurate record of the problem;
  - it tests motivation and cooperation of the child and the family; and
  - it acts as a positive reinforcement for the desired behavior.
- Fluid restriction after 6 O' clock in the evening.
- Interruption of child's sleep and emptying bladder in the toilet.

- Bell and pad technique: It is based on classical conditioning principle. A bell is attached to the napkin or panties and when the child passes urine, the alarm goes off, the child then has to wake up, change his napkin, bed sheets, etc. Reinforcement is given for dry nights.
- Medications: Tricyclic antidepressants like imipramine or amitriptyline, 25-50 mg at night. The mechanism of action is unknown, but results have demonstrated its effectiveness.
- The parents should be instructed not to blame the child in any way. On no account should the child be embarrassed or humiliated, which will only serve to aggravate the problem.

**Non-organic Encopresis**

It is the repeated voluntary or involuntary passage of feces, usually of normal or near normal consistency, in places not appropriate for that purpose in the individual's socio-cultural setting.

**Management**

- Family tensions regarding the symptoms must be reduced and a non-punitive atmosphere must be created. Parental guidance and family therapy often is needed.
- Behavioral techniques, e.g. star charts, in which the child places a star on a chart for dry or continent nights.
- Individual psychotherapy to gain the co-operation and trust of the child.

**Feeding Disorder of Infancy and Childhood**

It generally involves refusal of food and extreme faddiness in the presence of an adequate food supply and reasonably competent caregiver and the absence of organic disease. There may or may not be associated rumination (repeated regurgitation without nausea or gastrointestinal illness).

**Pica**

Pica of infancy and childhood is characterized by eating non-nutritive substances (soil, paint

chipping, paper etc). Treatment consists of common-sense precautions to keep the child away from abnormal items of diet. Pica usually diminishes as the child grows older.

### Stereotyped Movement Disorders

These disorders are characterized by voluntary, repetitive, stereotyped, nonfunctional, often rhythmic movements that do not form part of any recognized psychiatric or neurological condition. The movements include body rocking, head rocking, hair plucking hair twisting, finger flicking, mannerisms and hand flapping.

#### *Management*

- Individual and family interventions
- Behavioral strategies

### Stuttering (Stammering)

It refers to frequent hesitation or pauses in speech characterized by frequent repetition or prolongation of sounds or syllables or words, disrupting rhythmic flow of speech. The usual treatment is speech therapy.

### REVIEW QUESTIONS

- Classification of childhood psychiatric disorders (Feb 2001)

- Definition and etiology of mental retardation (Feb 2000, Oct 2004, Apr 2006)
- Classification of mental retardation (Feb 2001, Nov 2003)
- Profound mental retardation (Oct 2005)
- Mental retardation (Nov 2002)
- Role of a nurse in the prevention of mental retardation
- Nursing management of a mentally retarded child (Nov 2002)
- Habilitation of mentally retarded child (Nov 2001)
- Nursing management of an autistic child
- Infantile autism (Oct 2000)  
Autism (Nov 2003, Oct 2004)
- Attention deficit hyperactive disorder (Nov 2002, Apr 2003)
- Nursing management of a child with hyperkinetic disorder
- Conduct disorder (Nov 2001, Apr 2002)
- Juvenile delinquency (Feb 2000, Apr 2006)
- Enuresis (Feb 2001, Apr 2002, Apr 2004, Oct 2004)
- Mutism (Nov 2001)
- Tic disorder (Apr 2002)
- Nursing management of childhood psychiatric disorders (Apr 2006)
- Behavioral disorders in children (Oct 2004)
- Neurotic disorders of childhood (Nov 2003)

# 14

## *Therapeutic Modalities in Psychiatry*

### SOMATIC THERAPIES

- Psychopharmacology
  - Antipsychotics
  - Antidepressants
  - Lithium and Other Mood Stabilizing Drugs
  - Anxiolytics and Hypnotics
  - Antiparkinsonian Agents
  - Antabuse Drugs
  - Drugs Used In Child Psychiatry
- Electroconvulsive Therapy
- Psychosurgery

### PSYCHOLOGICAL THERAPIES

- Psychoanalytic Therapy
- Behavior Therapy
- Cognitive Therapy
- Hypnosis
- Abreaction Therapy
- Relaxation Therapies
- Individual Psychotherapy
- Supportive Psychotherapy
- Group Therapy
- Family and Marital Therapy

### MILIEU THERAPY

### THERAPEUTIC COMMUNITY

### ACTIVITY THERAPY

- Occupational Therapy
- Recreational Therapy
- Educational Therapy
- Biblio Therapy
- Play Therapy
- Music Therapy
- Dance Therapy
- Art Therapy
- Implications of Activity Therapies For Nursing Practice

one treatment. These treatment methods vary from patient to patient. Some patients do not want treatment and may not cooperate with the doctors and nurses. Some do not realize that they are ill and may actively resist all forms of treatment.

The nurse has an extremely important role to play in the treatment of the mentally ill. She is the one who has closer contact with the patient than any other members of the hospital team. She also has a greater opportunity to get to know him and report on his improvement.

The various treatment modalities in psychiatry are broadly divided as:

- Somatic (physical) therapies
- Psychological therapies

Other therapies included in this unit are:

- Milieu therapy
- Therapeutic community
- Activity therapy

### **SOMATIC (PHYSICAL) THERAPIES**

#### **Psychopharmacology**

The understanding of the biological regulation of thought, behavior and mood is the basis of all somatic therapies used in modern psychiatry. Psychopharmacological agents are now the first-line treatment for almost every psychiatric ailment. With the growing availability of a wide range of drugs to treat mental illness, the nurse practicing in modern psychiatric settings needs to have a sound knowledge of the pharmacokinetics involved , the benefits and potential risks of pharmacotherapy, as well as her own role and responsibility.

Patients suffering from physical illnesses are given specific treatment because the causes are specific and the signs and symptoms are specific. In a psychiatric setting the treatment may not be so specific and most patients are given more than

The various drugs used in psychiatry are called as psychotropic (or psychoactive) drugs. They are so called because of their significant effect on higher mental functions. There are about seven classes of psychotropic drugs. Before going into a detailed description of each, a few guidelines are given below regarding the administration of drugs in psychiatry in general. The specific responsibilities are mentioned separately under each class.

### *General Guidelines Regarding Drug Administration in Psychiatry*

- The nurse should not administer any drug unless there is a written order. Do not hesitate to consult the doctor when in doubt about any medication.
- All medications given must be charted on the patient's case record sheet.
- In giving medication:
  - always address the patient by name and make certain of his identification
  - do not leave the patient until the drug is swallowed
  - do not permit the patient to go to the bathroom to take the medication
  - do not allow one patient to carry medicine to another.
- If it is necessary to leave the patient to get water, do not leave the tray within the reach of the patient.
- Do not force oral medication because of the danger of aspiration. This is especially important in stuporous patients.
- Check drugs daily for any change in color, odor and number.
- Bottles should be tightly closed and labeled. Labels should be written legibly and in bold lettering. Poison drugs are to be legibly labeled and to be kept in separate cupboard.
- Make sure that an adequate supply of drugs is on hand, but do not overstock.
- Make sure no patient has access to the drug cupboard.
- Drug cupboards should always be kept locked when not in use. Never allow a patient or

worker to clean the drug cupboard. The drug cupboard keys should not be given to patients.

### *Classification of Psychotropic Drugs*

1. Antipsychotics
2. Antidepressants
3. Mood stabilizing drugs
4. Anxiolytics and hypnotics
5. Antiepileptic drugs
6. Antiparkinsonian drugs
7. Miscellaneous drugs which include stimulants, drugs used in eating disorders, drugs used in deaddiction, drugs used in child psychiatry, vitamins, calcium channel blockers, etc.

### **Antipsychotics**

Antipsychotics are those psychotropic drugs, which are used for the treatment of psychotic symptoms. These are also known as neuroleptics (as they produce neurological side-effects), major tranquilizers, D2-receptor blockers and anti-schizophrenic drugs.

### *Classification: See Table 14.1*

#### *Indications*

##### *Organic psychiatric disorders*

- Delirium
- Dementia
- Delirium tremens
- Drug-induced psychosis and other organic mental disorders

##### *Functional disorders*

- Schizophrenia
- Schizoaffective disorders
- Paranoid disorders

##### *Mood disorders*

- Mania
- Major depression with psychotic symptoms

##### *Childhood disorders*

- Attention-deficit hyperactivity disorder
- Autism
- Enuresis
- Conduct disorder

**Table 14.1:** Classification of antipsychotic drugs

| Class                    | Examples of drugs      | Trade name                        | Oral dose mg/day | Parenteral dose (mg)        |
|--------------------------|------------------------|-----------------------------------|------------------|-----------------------------|
| Phenothiazines           | Chlorpromazine         | Megatil<br>Largactil<br>Tranchlor | 300-1500         | 50-100<br>IM only           |
|                          | Trifluromazine         | Siquil                            | 100-400          | 30-60 IM only               |
|                          | Thioridazine           | Thioril, Melleril                 | 300-800          |                             |
|                          | Trifluoperazine        | Ridazin                           |                  |                             |
|                          | Fluphenazine decanoate | Espazine                          | 15-60            | 1-5 IM                      |
|                          |                        | Prolinate                         | -                | 25-50 IM<br>every 1-3 weeks |
| Thioxanthenes            | Flupenthixol           | Fluanxol                          | 3-40             |                             |
| Butyrophenones           | Haloperidol            | Senorm, Serenace                  | 5-100            | 5-20 IM                     |
| Diphenylbutyl            | Pimozide               | Orap                              | 4-20             |                             |
| Piperidines              | Penfluridol            | Flumap                            | 20-60 weekly     | -                           |
| Indolic derivatives      | Molindone              | Mobam                             | 50-225           | -                           |
| Dibenzoxazepines         | Loxapine               | Loxapac                           | 25-100           | -                           |
| Atypical anti-psychotics | Clozapine              | Sizopin, Lozapin                  | 50-450           | -                           |
|                          | Risperidone            | Sizodon, Sizomax                  | 2-10             | -                           |
|                          | Olanzapine             | Oleanz                            | 10-20 mg         | -                           |
|                          | Quetiapine             | Qutan                             | 150-750 mg       | -                           |
|                          | Ziprasidone            | Zisper                            | 20-80 mg         | -                           |
|                          | Reserpine              | Serpasil                          | 0.5-50           | -                           |

#### Neurotic and other psychiatric disorders

- Anorexia nervosa
- Intractable obsessive-compulsive disorder
- Severe, intractable and disabling anxiety

#### Medical disorders

- Huntington's chorea
- Intractable hiccough
- Nausea and vomiting
- Tic disorder
- Eclampsia
- Heat stroke
- Severe pain in malignancy
- Tetanus

#### Pharmacokinetics

Antipsychotics when administered orally are absorbed variably from the gastrointestinal tract, with uneven blood levels. They are highly bound to plasma as well as tissue proteins. Brain con-

centration is higher than plasma concentration. They are metabolized in the liver, and excreted mainly through the kidneys. The elimination half-life varies from 10 to 24 hours.

Most of the antipsychotics tend to have a therapeutic window. If the blood level is below this window, the drug is ineffective. If the blood level is higher than the upper limit of the window, there is toxicity or the drug is again ineffective.

#### Mechanism of Action

Antipsychotic drugs block D2 receptors in the mesolimbic and mesofrontal systems (concerned with emotional reactions). Sedation is caused by alpha-adrenergic blockade. Anti dopaminergic actions on basal ganglia are responsible for causing EPS (Extra Pyramidal Symptoms).

Atypical antipsychotics have antiserotonergic (5-hydroxytryptamine or 5-HT) antiadrenergic

and antihistaminergic actions. These are therefore called as serotonin-dopamine antagonists.

### *Adverse Effects of Antipsychotic Drugs*

#### I. *Extrapyramidal symptoms (EPS)*

1. *Neuroleptic-induced parkinsonism:* Symptoms include rigidity, tremors, bradykinesia, stooped posture, drooling, akinesia, ataxia, etc. The disorder can be treated with anticholinergic agents.
2. *Acute dystonia:* Dystonic movements results from a slow sustained muscular spasm that lead to an involuntary movement. Dystonia can involve the neck, jaw, tongue and the entire body (opisthotonus). There is also involvement of eyes leading to upward lateral movement of the eye known as oculogyric crisis. Dystonias can be prevented by anticholinergics, antihistaminergics, dopamine agonists, beta-adrenergic antagonists, benzodiazepines, etc.
3. *Akathisia:* Akathisia is a subjective feeling of muscular discomfort that can cause patients to be agitated, restless and feel generally dysphoric. Akathisia can be treated with propranolol, benzodiazepines and clonidine.
4. *Tardive dyskinesia:* It is a delayed adverse effect of antipsychotics. It consists of abnormal, irregular choreoathetoid movements of the muscles of the head, limbs and trunk. It is characterized by chewing, sucking, grimacing and peri-oral movements.
5. *Neuroleptic malignant syndrome:* This is a rare but serious disorder occurring in a small minority of patients taking neuroleptics, especially high-potency compounds.

The onset is often, but not invariably, in the first 10 days of treatment. The clinical picture includes the rapid onset (usually over 24-72 hours) of severe motor, mental and autonomic disorders. The prominent *motor symptom* is generalized muscular hypertonicity. Stiffness of the muscles in the throat and chest may cause dysphasia, and dyspnea. The *mental symptoms* include akinetic mutism, stupor or impaired consciousness. Hyper-

pyrexia develops with evidence of *autonomic* disturbances in the form of unstable blood pressure, tachycardia, excessive sweating, salivation, and urinary incontinence. In the blood, Creatinine Phospho Kinase [CPK] levels may be raised to very high levels, and the white cell count may be increased. Secondary features may include pneumonia, thromboembolism, cardiovascular collapse, and renal failure.

The syndrome lasts for one to two weeks after stopping the drug.

(See Chapter 18, p. 244 for management).

#### II. *Autonomic side-effects:* Dry mouth, constipation, cycloplegia, mydriasis, urinary retention, orthostatic hypotension, impotence and impaired ejaculation.

#### III. *Seizures*

#### IV. *Sedation*

#### V. *Other effects*

- Agranulocytosis (especially for clozapine)
- Sialorrhea or increased salivation (especially for clozapine)
- Weight gain
- Jaundice
- Dermatological effects (contact dermatitis, photosensitive reaction)

### *Nurse's Responsibility for a Patient Receiving Antipsychotics.*

- Instruct the patient to take sips of water frequently to relieve dryness of mouth. Frequent mouth washes, use of chewing gum, applying glycerine on the lips are also helpful.
- A high-fiber diet, increased fluid intake and laxatives if needed, help to reduce constipation.
- Advise the patient to get up from the bed or chair very slowly. Patient should sit on the edge of the bed for one full minute dangling his feet, before standing up. Check BP before and after medication is given. This is an important measure to prevent falls and other complications resulting from orthostatic hypotension.
- Differentiate between akathisia and agitation and inform the physician. A change of drug

- may be necessary if side-effects are severe. Administer antiparkinsonian drugs as prescribed.
- Observe the patient regularly for abnormal movements.
  - Take all seizure precautions.
  - Patient should be warned about driving a car or operating machinery when first treated with antipsychotics. Giving the entire dose at bedtime usually eliminates any problem from sedation.
  - Advise the patient to use sunscreen measures (use of full sleeves, dark glasses etc) for photosensitive reactions.
  - Teach the importance of drug compliance, side-effects of drugs and reporting if too severe, regular follow-ups. Give reassurance and reduce unfounded fears and anxieties.
  - A patient receiving clozapine is at risk for developing agranulocytosis. Monitor TC, DC essentially in the first few weeks of treatment. Stop the drug if the WBC count drops to less than 3000/mm<sup>3</sup> of blood. The patient should also be told to report if sore throat or fever develop, which might indicate infection.
  - Seizure precautions should also be taken as clozapine reduces seizure threshold. The dose should be regulated carefully and the patient may also be put on anticonvulsants such as eptoin.

### Antidepressants

Antidepressants are those drugs, which are used for the treatment of depressive illness. These are also called as mood elevators or thymoleptics.

*Classification:* See Table 14.2

#### Indications

##### Depression

- Depressive episode
- Dysthymia
- Reactive depression
- Secondary depression
- Abnormal grief reaction

##### Childhood psychiatric disorders

- Enuresis
- Separation anxiety disorder
- Somnambulism
- School phobia
- Night terrors

##### Other psychiatric disorders

- Panic attack
- Generalised anxiety disorder
- Agoraphobia, social phobia
- OCD with or without depression
- Eating disorder
- Borderline personality disorder
- Post-traumatic stress disorder
- Depersonalization syndrome

##### Medical disorders

- Chronic pain

**Table 14.2:** Classification of antidepressants

| Class   | Examples of drugs   | Trade names  | Oral dosage (mg/day)                           |
|---|---|--|--|
| Tricyclic antidepressants (TCAs)                | Imipramine<br>Amitriptyline<br>Clomipramine<br>Dothiepin<br>Mianserin | Antidep<br>Tryptomer<br>Anafranil<br>Prothiadene<br>Depnon | 75-300<br>75-300<br>75-300<br>75-300<br>30-120 |
| Selective serotonin reuptake Inhibitors (SSRIs) | Fluoxetine<br>Sertraline  | Fludac<br>Serenata   | 10-80<br>50-200                                |
| Dopaminergic antidepressants                    | Fluvoxamine   | Faverin  | 50-300   |
| Atypical antidepressants                        | Amineptine  | Survector  | 100-400  |
| Monoamine oxidase inhibitors (MAOIs)            | Trazodone<br>Isocarboxazid  | Trazalon<br>Marplan  | 150-600<br>10-30                               |

- Migraine
- Peptic ulcer disease

### Pharmacokinetics

Antidepressants are highly lipophilic and protein-bound. The half-life is long and usually more than 24 hours. It is predominantly metabolized in the liver.

### Mechanism of Action

The exact mechanism is unknown. The predominant action is by increasing catecholamine levels in the brain.

TCAs are also called as Mono Amine Reuptake Inhibitors (MARIs). The main mode of action is by blocking the reuptake of norepinephrine(NE) and/or serotonin (5-HT) at the nerve terminals, thus increasing the NE and 5-HT levels at the receptor site.

MAOIs instead act on MAO (monoamine oxidase), which is responsible for the degradation of catecholamines after re-uptake. The final effect is the same, a functional increase in the NE and 5-HT levels at the receptor site. The increase in brain amine levels is probably responsible for the antidepressant action. It takes about 5 to 10 days for MAOIs and 2 to 3 weeks for TCAs to bring down depressive symptoms.

SSRIs act by inhibiting the re-uptake of serotonin and increasing its levels at the receptor site.

### Side Effects

1. *Autonomic side-effects:* Dry mouth, constipation, cycloplegia, mydriasis, urinary retention, orthostatic hypotension, impotence, impaired ejaculation, delirium and aggravation of glaucoma.
2. *CNS effects:* Sedation, tremor and other extra-pyramidal symptoms, withdrawal syndrome, seizures, jitteriness syndrome, precipitation of mania.
3. *Cardiac side-effects:* Tachycardia, ECG changes, arrhythmias, direct myocardial depression, quinidine-like action (decreased conduction time).

4. *Allergic side-effects:* Agranulocytosis, cholestatic jaundice, skin rashes, systemic vasculitis.
5. *Metabolic and endocrine side-effects:* Weight gain.
6. *Special effects of MAOI drugs:* Hypertensive crises, severe hepatic necrosis, hyperpyrexia.

### Nurse's Responsibility for a Patient Receiving Antidepressants

Most of the nurse's responsibilities for a patient on antidepressants are the same as for a patient receiving antipsychotics (see p. 174). In addition:

- Patients on MAOIs should be warned against the danger of ingesting tyramine-rich foods which can result in hypertensive crisis. Some of these foods are beef liver, chicken liver, fermented sausages, dried fish, overripe fruits, chocolate and beverages like wine, beer and coffee.
- Report promptly if occipital headache, nausea, vomiting, chest pain or other unusual symptoms occur ; these can herald the onset of hypertensive crisis.
- Instruct the patient not to take any medication without prescription.
- Caution the patient to change his position slowly to minimize orthostatic hypotension.
- Strict monitoring of vitals, especially blood pressure is essential.

### Lithium and Other Mood Stabilizing Drugs

Mood stabilizers are used for the treatment of bipolar affective disorders. Some commonly used mood stabilizers are:

- Lithium
- Carbamazepine
- Sodium valproate

### Lithium

Lithium is an element with atomic number 3 and atomic weight 7. It was discovered by FJ Cade in 1949, and is a most effective and commonly used drug in the treatment of mania.

### Indications

- Acute mania
- Prophylaxis for bipolar and unipolar mood disorder.

- Schizoaffective disorder
- Cyclothymia
- Impulsivity and aggression
- Other disorders:
  - premenstrual dysphoric disorder
  - bulimia nervosa
  - borderline personality disorder
  - episodes of binge drinking
  - trichotillomania
  - cluster headaches

### **Pharmacokinetics**

Lithium is readily absorbed with peak plasma levels occurring 2-4 hours after a single oral dose of lithium carbonate. Lithium is distributed rapidly in liver and kidney and more slowly in muscle, brain and bone. Steady state levels are achieved in about 7 days. Elimination is predominantly via kidneys. Lithium is reabsorbed in the proximal tubules and is influenced by sodium balance. Depletion of sodium can precipitate lithium toxicity.

### **Mechanism of Action**

The probable mechanisms of action can be:

- It accelerates presynaptic re-uptake and destruction of catecholamines, like norepinephrine
- It inhibits the release of catecholamines at the synapse.
- It decreases postsynaptic serotonin receptor sensitivity.

All these actions result in decreased catecholamine activity, thus ameliorating mania.

### **Dosage**

Lithium is available in the market in the form of the following preparations:

- Lithium carbonate: 300mg tablets (e.g. Licab); 400mg sustained release tablets (e.g. Lithosun-SR)
- Lithium citrate: 300mg/5ml liquid.

The usual range of dose per day in acute mania is 900-2100 mg given in 2-3 divided doses. The treatment is started after serial lithium estima-

tion is done after a loading dose of 600 mg or 900 mg of lithium to determine the pharmacokinetics.

### **Blood Lithium Levels**

- Therapeutic levels = 0.8 – 1.2 mEq/L (for treatment of acute mania)
- Prophylactic levels = 0.6 – 1.2 mEq/L (for prevention of relapse in bipolar disorder)
- Toxic lithium levels > 2.0 mEq/L

### **Side Effects**

1. *Neurological*: Tremors, motor hyperactivity, muscular weakness, cogwheel rigidity, seizures, neurotoxicity (delirium, abnormal involuntary movements, seizures, coma).
2. *Renal*: Polydipsia, polyuria, tubular enlargement, nephrotic syndrome.
3. *Cardiovascular*: T-wave depression.
4. *Gastrointestinal*: Nausea, vomiting, diarrhea, abdominal pain and metallic taste.
5. *Endocrine*: Abnormal thyroid function, goiter and weight gain.
6. *Dermatological*: Acneiform eruptions, papular eruptions and exacerbation of psoriasis.
7. *Side-effects during pregnancy and lactation*: Teratogenic possibility, increased incidence of Ebstein's anomaly (distortion and downward displacement of tricuspid valve in right ventricle) when taken in first trimester. Secreted in milk and can cause toxicity in infant.
8. *Signs and symptoms of lithium toxicity (serum lithium level >2.0 mEq/L)*:
  - ataxia
  - coarse tremor (hand)
  - nausea and vomiting
  - impaired memory
  - impaired concentration
  - nephrotoxicity
  - muscle weakness
  - convulsions
  - muscle twitching
  - dysarthria
  - lethargy
  - confusion
  - coma
  - hyperreflexia
  - nystagmus

### *Management of Lithium Toxicity*

- Discontinue the drug immediately.
- For significant short-term ingestions, residual gastric content should be removed by induction of emesis, gastric lavage and adsorption with activated charcoal.
- If possible instruct the patient to ingest fluids.
- Assess serum lithium levels, serum electrolytes, renal functions, ECG as soon as possible.
- Maintenance of fluid and electrolyte balance.
- In a patient with serious manifestations of lithium toxicity, hemodialysis should be initiated.

### *Contraindications of Lithium Use*

- Cardiac, renal, thyroid or neurological dysfunctions
- Presence of blood dyscrasias
- During first trimester of pregnancy and lactation
- Severe dehydration
- Hypothyroidism
- History of seizures

### *Nurse's Responsibilities for a Patient Receiving Lithium*

*The pre-lithium work up:* A complete physical history, ECG, blood studies (TC, DC, FBS, BUN, creatinine, electrolytes) urine examination (routine and microscopic) must be carried out. It is important to assess renal function as renal side-effects are common and the drug can be dangerous in an individual with compromised kidney function. Thyroid functions should also be assessed, as the drug is known to depress the thyroid gland.

*To achieve therapeutic effect and prevent lithium toxicity, the following precautions should be taken:*

- Lithium must be taken on a regular basis, preferably at the same time daily (for example, a client taking lithium on TID schedule, who forgets a dose should wait until the next scheduled time to take lithium and not take twice the amount at one time, because lithium toxicity can occur).

- When lithium therapy is initiated, mild side-effects such as fine hand tremors, increased thirst and urination, nausea, anorexia etc may develop. Most of them are transient and do not represent lithium toxicity.
- Serious side-effects of lithium that necessitate its discontinuance include vomiting, extreme hand tremors, sedation, muscle weakness and vertigo. The psychiatrist should be notified immediately if any of these effects occur.
- Since polyuria can lead to dehydration with the risk of lithium intoxication, patients should be advised to drink enough water to compensate for the fluid loss.
- Various situations may require an adjustment in the amount of lithium administered to a client, such as the addition of a new medicine to the client's drug regimen, a new diet or an illness with fever or excessive sweating. In this connection, people involved in heavy outdoor labor are prone to excessive sodium loss through sweating. They must be advised to consume large quantities of water with salt, to prevent lithium toxicity due to decreased sodium levels. If severe vomiting or gastroenteritis develops, the patient should be told to report immediately to the doctor. These are the conditions that have a high potential for causing lithium toxicity by lowering serum sodium levels.
- Frequent serum lithium level evaluation is important. Blood for determination of lithium levels should be drawn in the morning approximately 12-14 hours after the last dose was taken.
- The patient should be told about the importance of regular followup. In every six months, blood sample should be taken for estimation of electrolytes, urea, creatinine, a full blood count, and thyroid function test.

### **Carbamazepine**

It is available in the market under different trade names like Tegretol, Mazetol, Zeptol and Zen Retard.

**Indications**

- Seizures-complex partial seizures, GTCS, seizures due to alcohol withdrawal .
- Psychiatric disorders- rapid cycling bipolar disorder, acute depression, impulse control disorder, aggression, psychosis with epilepsy, schizoaffective disorders, borderline personality disorder, cocaine withdrawal syndrome.
- Paroxysmal pain syndromes – trigeminal neuralgia and phantom limb pain.

**Dosage**

The average daily dose is 600-1800 mg orally, in divided doses. The therapeutic blood levels are 6-12 µg/ml. Toxic blood levels are attained at more than 15 µg/ml.

**Mechanism of Action**

Its mood stabilizing mechanism is not clearly established. Its anticonvulsant action may however be by decreasing synaptic transmission in the CNS.

**Side Effects**

Drowsiness, confusion, headache, ataxia, hypertension, arrhythmias, skin rashes, Steven-Johnson syndrome, nausea, vomiting, diarrhea, dry mouth, abdominal pain, jaundice, hepatitis, oliguria, leukopenia, thrombocytopenia, bone marrow depression leading to aplastic anemia.

**Nurse's Responsibilities**

- Since the drug may cause dizziness and drowsiness advise him to avoid driving and other activities requiring alertness.
- Advise patient not to consume alcohol when he is on the drug.
- Emphasize the importance of regular follow-up visits and periodic examination of blood count and monitoring of cardiac, renal, hepatic and bone marrow functions.

**Sodium Valproate (Encorate chrono, valparin, Epilex, Epival)****Indications**

- Acute mania, prophylactic treatment of bipolar I disorder, rapid cycling bipolar disorder.
- Schizoaffective disorder.
- Seizures.
- Other disorders like bulimia nervosa, obsessive-compulsive disorder, agitation and PTSD.

**Mechanism of Action**

The drug acts on gamma-aminobutyric acid (GABA) an inhibitory amino acid neurotransmitter. GABA receptor activation serves to reduce neuronal excitability.

**Dosage**

The usual dose is 15mg/kg/day with a maximum of 60 mg/kg/day orally.

**Side Effects**

Nausea, vomiting, diarrhea, sedation, ataxia, dysarthria, tremor, weight gain, loss of hair, thrombocytopenia, platelet dysfunction.

**Nurse's Responsibilities**

- Explain to the patient to take the drug immediately after food to reduce GI irritation.
- Advise to come for regular follow-up and periodic examination of blood count, hepatic function and thyroid function. Therapeutic serum level of valproic acid is 50-100 micrograms/ml.

**Anxiolytics (Anti-anxiety drugs) and Hypnosedatives**

These are also called as minor tranquilizers. Most of them belong to the benzodiazepine group of drugs.

**Classification**

1. *Barbiturates:* Example, phenobarbital, pentobarbital, secobarbital and thiopentone.

2. *Non-barbiturate non-benzodiazepine anti-anxiety agents:* Example, Meprobamate, glutethimide, ethanol, diphenhydramine and methaqualone.
3. *Benzodiazepines:* Presently benzodiazepines are the drugs of first choice in the treatment of anxiety, and for the treatment of insomnia.
  - Very short-acting: Example, Triazolam, Midazolam.
  - Short-acting: Example, Oxazepam (Serepax), Lorazepam (Ativan, Trapex, Larpose), Alprazolam (Restyl, Trika, Alzolam, Quiet, Anxit).
  - Long-acting: Example, Chlordiazepoxide (Librium), Diazepam (Valium, Calmose), Clonazepam (Lonazep), Flurazepam (Nindral), Nitrazepam (Dormin).

### *Indications for Benzodiazepines*

- Anxiety disorders
- Insomnia
- Depression
- Panic disorder and social phobia
- Obsessive-compulsive disorder
- Post-traumatic stress disorder
- Bipolar I disorder
- Other psychiatric indications include alcohol withdrawal, substance-induced and psychotic agitation

### *Dosage (mg/day)*

Alprazolam: 0.5 – 6 PO

Oxazepam: 15-120 PO

Lorazepam: 2-6 PO/IV/IM

Diazepam: 2-10 PO/IM/ slow IV

Clonazepam: 0.5-20 PO/IM

Chlordiazepoxide: 15-100 PO ; 50-100 slow IV

Nitrazepam: 5-20 PO

### *Mechanism of Action*

Benzodiazepines bind to specific sites on the GABA receptors and increase GABA level. Since GABA is an inhibitory neurotransmitter, it has a calming effect on the central nervous system, thus reducing anxiety.

### *Side Effects*

Nausea, vomiting, weakness, vertigo, blurring of vision, body aches, epigastric pain, diarrhea, impotence, sedation, increased reaction time, ataxia, dry mouth, retrograde amnesia, impairment of driving skills, dependence and withdrawal symptoms (the drug should be withdrawn slowly, as a result).

### *Nurse's Responsibility in the Administration of Benzodiazepines*

- Administer with food to minimize gastric irritation.
- Advise the patient to take medication exactly as directed. Abrupt withdrawal may cause insomnia, irritability and sometimes even seizures.
- Explain about adverse effects and advise him to avoid activities that require alertness.
- Caution the patient to avoid alcohol or any other CNS depressants along with benzodiazepines ; also instruct him not to take any over-the-counter (OTC) medications.
- If IM administration is preferred give deep IM.
- For IV administration do not mix with any other drug. Give slow IV as respiratory or cardiac arrest can occur; monitor vital signs during IV administration. Prevent extravasations since it can cause phlebitis and venous thrombosis.

### **Antiparkinsonian Agents**

In clinical practice anticholinergic drugs, amantadine and the antihistamines have their primary use as treatments for medication-induced movement disorders, particularly neuroleptic-induced parkinsonism, acute dystonia and medication-induced tremor.

### *Anticholinergics*

- Trihexyphenidyl
- Benztropine
- Biperiden

**Dopaminergic Agents**

- Bromocriptine
- Carbidopa/Levodopa

**Monoamine Oxidase Type B Inhibitors**

- Selegiline

*Trihexyphenidyl (Artane, Trihexane, Trihexy, Pacitane)*

**Indications**

- Drug-induced parkinsonism.
- Adjunct in the management of parkinsonism.

**Mechanism of Action**

It acts by increasing the release of dopamine from presynaptic vesicles, blocking the re-uptake of dopamine into presynaptic nerve terminals or by exerting an agonist effect on postsynaptic dopamine receptors.

Trihexyphenidyl reaches peak plasma concentrations in 2-3 hours after oral administration and has a duration of action of upto 12 hours.

**Dosage**

1-2 mg per day orally initially. Maximum dose up to 15 mg/day in divided doses.

**Side Effects**

Dizziness, nervousness, drowsiness, weakness, headache, confusion, blurred vision, mydriasis, tachycardia, orthostatic hypotension, dry mouth, nausea, constipation, vomiting, urinary retention and decreased sweating.

**Nurse's Responsibilities**

- Assess parkinsonian and extrapyramidal symptoms. Medication should be tapered gradually.
- Caution patient to make position changes slowly to minimize orthostatic hypotension.
- Instruct the patient about frequent rinsing of mouth and good oral hygiene.
- Caution patient that this medication decreases perspiration, and over-heating may occur during hot weather.

**Antabuse Drugs**

**Disulfiram** is an important drug in this class and is used to ensure abstinence in the treatment of alcohol dependence. Its main effect is to produce a rapid and violently unpleasant reaction in a person who ingests even a small amount of alcohol while taking disulfiram.

(Refer Chapter 11 p. 133 for a detailed description on disulfiram)

**Drugs Used in Child Psychiatry****Clonidine****Indications**

- Control of withdrawal symptoms from opioids
- Tourette's disorder
- Control of aggressive or hyperactive behavior in children
- Autism

**Mechanism of Action**

- Alpha 2 - adrenergic receptor agonist.
- The agonist effects of clonidine on presynaptic alpha 2-adrenergic receptors result in a decrease in the amount of neurotransmitter released from the presynaptic nerve terminals. This decrease serves generally to reset the sympathetic tone at a lower level and to decrease arousal.

**Dosage**

Usual starting dosage is 0.1mg orally twice a day; the dosage can be raised by 0.3 mg a day to an appropriate level.

**Side Effects**

Dry mouth, dryness of eyes, fatigue, irritability, sedation, dizziness, nausea, vomiting, hypotension and constipation.

**Nurse's Responsibility**

Monitor BP, the drug should be withheld if the patient becomes hypotensive.

Advise frequent mouth rinses and good oral hygiene for dry mouth.

### **Methylphenidate (Ritalin)**

Methylphenidate, dextroamphetamine and pemoline are sympathomimetics.

#### *Indications*

- Attention-deficit hyperactivity disorder
- Narcolepsy
- Depressive disorders
- Obesity

#### *Mechanism of Action*

Sympathomimetics cause the stimulation of alpha and beta-adrenergic receptors directly as agonists and indirectly by stimulating the release of dopamine and norepinephrine from pre-synaptic terminals. Dextroamphetamine and methylphenidate are also inhibitors of catecholamine reuptake, especially dopamine reuptake and inhibitors of monoamino oxidase. The net result of these activities is believed to be the stimulation of several brain regions.

#### *Dosage*

Starting dose is 5-10 mg per day orally, maximum daily dose is 80 mg/day.

#### *Side Effects*

Anorexia or dyspepsia, weight loss, slowed growth, dizziness, insomnia or nightmares, dysphoric mood, tics and psychosis.

#### *Nurse's Responsibilities*

- Assess mental status for change in mood, level of activity, degree of stimulation and aggressiveness.
- Ensure that patient is protected from injury.
- Keep stimuli low and environment as quiet as possible to discourage over stimulation.
- To decrease anorexia, the medication may be administered immediately after meals. The patient should be weighed regularly (at least

weekly) during hospitalization and at home while on therapy with CNS stimulants, due to the potential for anorexia/weight loss and temporary interruptions of growth and development.

- To prevent insomnia administer last dose at least 6 hours before bedtime..
- In children with behavioral disorders a drug 'holiday' should be attempted periodically under the direction of the physician to determine effectiveness of the medication and the need for continuation.
- Ensure that parents are aware of the delayed effects of Ritalin. Therapeutic response may not be seen for 2-4 weeks; the drug should not be discontinued for lack of immediate results.
- Inform parents that OTC (over-the-counter) medications should be avoided while the child is on stimulant medication. Some OTC medications, particularly cold and hay fever preparations contain certain sympathomimetic agents that could compound the effects of the stimulant and create drug interactions that may be toxic to the child.
- Ensure that parents are aware that the drug should not be withdrawn abruptly. Withdrawal should be gradual and under the direction of the physician.

### **Electroconvulsive Therapy**

Electroconvulsive therapy is a type of somatic treatment first introduced by Bini and Cerletti in April 1938. From 1980 onwards ECT is being considered as a unique psychiatric treatment.

Electroconvulsive therapy is the artificial induction of a grandmal seizure through the application of electrical current to the brain. The stimulus is applied through electrodes that are placed either bilaterally in the fronto-temporal region, or unilaterally on the non-dominant side (right side of head in a right-handed individual).

#### *Parameters of Electrical Current Applied*

Standard dose according to American Psychiatric Association, 1978:

- Voltage - 70-120 volts.
- Duration - 0.7-1.5 seconds

#### Type of Seizure Produced

- grandmal seizure—tonic phase lasting for 10 - 15 seconds.
- clonic phase lasting for 30-60 seconds

#### Mechanism of Action

The exact mechanism of action is not known. One hypothesis states that ECT possibly affects the catecholamine pathways between diencephalon (from where seizure generalization occurs) and limbic system (which may be responsible for mood disorders), also involving the hypothalamus.

#### Types of ECT

*Direct ECT:* In this, ECT is given in the absence of anesthesia and muscular relaxation. This is not a commonly used method now.

*Modified ECT:* Here ECT is modified by drug-induced muscular relaxation and general anesthesia.

#### Frequency and Total Number of ECT

Frequency: Three times per week or as indicated. Total number: 6 to 10; upto 25 may be preferred as indicated.

#### Application of Electrodes

*Bilateral ECT:* Each electrode is placed 2.5-4 cm (1-1½ inch) above the midpoint, on a line joining the tragus of the ear and the lateral canthus of the eye.

*Unilateral ECT:* Electrodes are placed only on one side of head, usually non-dominant side (right side of head in a right-handed individual).

Unilateral ECT is safer, with much fewer side-effects particularly those of memory impairment.

#### Indications

- a. *Major depression:* With suicidal risk; with stupor; with poor intake of food and fluids;

melancholia with psychotic features with unsatisfactory response to drugs or where drugs are contraindicated or have serious side-effects.

- b. *Severe catatonia (functional):* With stupor; with poor intake of food and fluids; with unsatisfactory response to drug therapy, or when drugs are contraindicated or have serious side-effects.
- c. *Severe psychosis (schizophrenia or mania):* With risk of suicide, homicide or danger of physical assault; with depressive features; with unsatisfactory response to drug therapy, or when drugs are contraindicated or have serious side-effects.
- d. *Organic mental disorders:*
  - organic mood disorders.
  - organic psychosis
- e. *Other indications:* ECT is preferred to anti-depressant therapy in some cases, such as for clients with cardiac disease; when tricyclics are contraindicated because of the potential for dysrhythmias and congestive heart failure; and for pregnant women, in whom antidepressants place the fetus at risk for congenital defects.

#### Contraindications

- A. *Absolute:*
  - raised ICP (intracranial pressure)
- B. *Relative:*
  - cerebral aneurysm
  - cerebral hemorrhage
  - brain tumor
  - acute myocardial infarction
  - congestive heart failure
  - pneumonia or aortic aneurysm
  - retinal detachment

#### Complications of ECT

Life-threatening complications of ECT are rare. ECT does not cause any brain damage.

Fractures can sometimes occur in elderly patients with osteoporosis. In patients with a history of heart disease, dysrhythmias and respiratory arrest may occur.

### *Side Effects of ECT*

- Memory impairment.
- Drowsiness, confusion and restlessness.
- Poor concentration, anxiety.
- Headache, weakness/fatigue, backache, muscle aches.
- Dryness of mouth, palpitations, nausea, vomiting.
- Unsteady gait.
- Tongue bite and incontinence.

### *ECT Team*

Psychiatrist, anesthesiologist, trained nurses and aides should be involved in the administration of ECT.

### *Treatment Facilities*

There should be a suite of three rooms:

1. A pleasant, comfortable waiting room (pre-ECT room).
2. ECT room , which should be equipped with ECT machine and accessories ,an anesthetic appliance, suction apparatus, face masks, oxygen cylinders with adjustable flow valves, curved tongue depressors, mouth gags, resuscitation apparatus and emergency drugs. There should be immediate access to a defibrillator.
3. A well-equipped recovery room.

### *Role of the Nurse*

#### a *Pre-treatment evaluation*

- Detailed medical and psychiatric history including history of allergies.
- Assessment of patient's and family's knowledge of indications, side-effects, therapeutic effects and risks associated with ECT.
- An informed consent should be taken. Allay any unfounded fears and anxieties regarding the procedure.
- Assess baseline vital signs.
- Patient should be on empty stomach for 4-6 hours prior to ECT.
- Withhold night doses of drugs, which increase seizure threshold like diazepam, barbiturates and anticonvulsants.

- Withhold oral medications in the morning.
- Head shampooing in the morning since oil causes impedance of passage of electricity to brain.
- Any jewellery, prosthesis, dentures, contact lens, metallic objects and tight clothing should be removed from the patient's body.
- Empty bladder and bowel just before ECT.
- Administration of 0.6 mg atropine IM or SC 30 minutes before ECT, or IV just before ECT.

#### b. *Intra-procedure care*

- Place the patient comfortably on the ECT table in supine position.
- Stay with the patient to allay anxiety and fear.
- Assist in administering the anesthetic agent (thiopental sodium 3-5 mg/kg body weight) and muscle relaxant (1 mg/kg body weight of succinylcholine).
- Since the muscle relaxant paralyzes all muscles including respiratory muscles, patent airway should be ensured and ventilatory support should be started.
- Mouth gag should be inserted to prevent possible tongue bite.
- The place(s) of electrode placement should be cleaned with normal saline or 25 percent bicarbonate solution, or a conducting gel applied.
- Monitor voltage, intensity and duration of electrical stimulus given.
- Monitor seizure activity using cuff method.
- 100 percent oxygen should be provided.
- During seizure monitor vital signs, ECG, oxygen saturation, EEG, etc.
- Record the findings and medicines given in the patient's chart.

#### c. *Post-procedure care*

- Monitor vital signs.
- Continue oxygenation till spontaneous respiration starts.
- Assess for post-ictal confusion and restlessness.
- Take safety precautions to prevent injury (side-lying position and suctioning to prevent aspiration of secretions, use of side rails to prevent falls).

- If there is severe post-ictal confusion and restlessness, IV diazepam may be administered.
- Reorient the patient after recovery and stay with him until fully oriented.
- Document any findings as relevant in the patient's record.

### **Psychosurgery**

Psychosurgery is defined by APA's Task Force as "a surgical intervention, to sever fibers connecting one part of the brain with another, or to remove, destroy, or stimulate brain tissue, with the intent of modifying behavior, thought or mood disturbances, for which there is no underlying organic pathology."

#### *Indications*

- Severe psychiatric illness.
- Chronic duration of illness of about 10 years.
- Persistent emotional distress.
- Failure to respond to all other therapies.
- High risk of suicide.

#### *Major Surgical Procedures*

- Stereotactic subcaudate tractotomy.
- Stereotactic limbic leucotomy.
- Stereotactic bilateral amygdalotomy

Nursing care for a patient undergoing psychosurgery is the same as for any neurosurgical procedure.

### **PSYCHOLOGICAL THERAPIES**

There are several kinds of psychological therapies:

- Psychoanalytic therapy
- Behavior therapy
- Cognitive therapy
- Hypnosis
- Abreaction therapy
- Relaxation therapies
- Individual psychotherapy
- Supportive psychotherapy
- Group therapy
- Family and marital therapy

### **Psychoanalytic Therapy**

- Psychoanalysis was first developed by Sigmund Freud at the end of the 19th century. The most important indication for psychoanalytical therapy is the presence of long-standing mental conflicts, which may be unconscious but produce symptoms. The aim of the therapy is to bring all repressed material to conscious awareness so that the patient can work towards a healthy resolution of his problems, which are causing the symptoms.
- Psychoanalysis makes use of *free association* and *dream analysis* to affect reconstruction of personality. Free association refers to the verbalization of thoughts as they occur, without any conscious screening. The psychoanalyst searches for patterns in the material that is verbalized and in the areas that are unconsciously avoided (such areas are identified as resistances).
- Analysis of the patient's dreams helps to gain additional insight into his problem and the resistances. Thus dreams symbolically communicate areas of intrapsychic conflict.
- The therapist then attempts to assist the patient to recognize his intrapsychic conflicts through the use of interpretation.
- The process is complicated by the occurrence of transference reactions. This refers to the patient's development of strong positive or negative feelings towards the analyst, and they represent the patient's past response to a significant other, usually a parent. The therapist's reciprocal response to the patient is called countertransference. Such reactions must be handled appropriately before progress can be made.
- The roles of the patient and psychoanalyst are explicitly defined by Freud. The patient is an active participant, freely revealing all thoughts exactly as they occur and describing all dreams. He is frequently in a recumbent position on a couch during therapy to induce relaxation, which facilitates free association. The psychoanalyst is a shadow-person. He

reveals nothing personal, nor does he give any directions to the patient. His verbal responses are for the most part brief and noncommittal, so as not to interfere with the associative flow. He departs from this style of communication when an interpretation of behavior is made to the patient.

- By termination of therapy, the patient is able to conduct his life according to an accurate assessment of external reality and is also able to relate to others uninhibited by neurotic conflicts.
- Psychoanalytical therapy is a long-term proposition. The patient is seen frequently, usually five times a week. It is therefore time-consuming and expensive.  
(Also Refer Chapter 4 p. 48 Psychoanalytical model).

### **Behavior Therapy**

It is a form of treatment for problems in which a trained person deliberately establishes a professional relationship with the client, with the objective of removing or modifying existing symptoms and promoting positive personality, growth and development.

Behavior therapy involves identifying maladaptive behaviors and seeking to correct these by applying the principles of learning derived from the following theories:

- Classical conditioning model by Ivan Pavlov (1936)
- Operant conditioning model by BF Skinner (1953)

### **Major Assumptions of Behavior Therapy**

Based on the above-mentioned theories, the following are the assumptions of behavior therapy:

- All behavior is learned (adaptive and maladaptive).
- Human beings are passive organisms that can be conditioned or shaped to do anything if correct responses are rewarded or reinforced.
- Maladaptive behavior can be unlearned and replaced by adaptive behavior if the person

receives exposure to specific stimuli and reinforcement for the desired adaptive behavior.

- Behavioral assessment is focused more on the current behavior rather than on historical antecedents.
- Treatment strategies are individually tailored. Behavior therapy is a short duration therapy, therapists are easy to train and it is cost-effective. The total duration of therapy is usually 6-8 weeks. Initial sessions are given daily but the later sessions are spaced out. Unlike psychoanalysis where the therapist is a shadow person, in behavior therapy both the patient and therapist are equal participants. There is no attempt to unearth an underlying conflict and the patient is not encouraged to explore his past.  
(Refer 'Behavior model' on p. 49 for further details)

### **Behavior Techniques**

(A) *Systematic desensitization* It was developed by Joseph Wolpe, based on the behavioral principle of counter conditioning. In this patients attain a state of complete relaxation and are then exposed to the stimulus that elicits the anxiety response. The negative reaction of anxiety is inhibited by the relaxed state, a process called reciprocal inhibition.

It consists of three main steps:

1. Relaxation training
2. Hierarchy construction
3. Desensitization of the stimulus

1. Relaxation training: There are many methods which can be used to induce relaxation, some of them are:

- Jacobson's progressive muscle relaxation
- Hypnosis
- Meditation or yoga
- Mental imagery
- Biofeedback

2. Hierarchy construction: Here the patient is asked to list all the conditions which provoke anxiety. Then he is asked to list them in a descending order of anxiety provocation.

3. Desensitization of the stimulus: This can either be done in reality or through imagination. At first, the lowest item in hierarchy is confronted. The patient is advised to signal whenever anxiety is produced. With each signal he is asked to relax. After a few trials, patient is able to control his anxiety gradually.

*Indications:*

- Phobias
- Obsessions
- Compulsions
- Certain sexual disorders

- B. *Flooding:* The patient is directly exposed to the phobic stimulus, but escape is made impossible. By prolonged contact with the phobic stimulus, the therapist's guidance and encouragement and his modeling behavior reduce anxiety.

*Indications:* Specific phobias

- C. *Aversion therapy:* Pairing of the pleasant stimulus with an unpleasant response, so that even in absence of the unpleasant response the pleasant stimulus becomes unpleasant by association. Punishment is presented immediately after a specific behavioral response and the response is eventually inhibited.

Unpleasant response is produced by electric stimulus, drugs, social disapproval or even fantasy.

*Indications:*

- Alcohol abuse
- Paraphilic
- Homosexuality
- Transvestism.

- D. *Operant conditioning procedures for increasing adaptive behavior*

1. Positive reinforcement: When a behavioral response is followed by a generally rewarding event such as food, praise or gifts, it tends to be strengthened and occurs more frequently than before the reward. This technique is used to increase desired behavior.
2. Token economy: This program involves giving token rewards for appropriate or desired target behaviors performed by the patient. The

token can later be exchanged for other rewards. For example on inpatient hospital wards, patients receive a reward for performing a desired behavior, such as tokens which they may use to purchase luxury items or certain privileges.

- E. *Operant conditioning procedures to teach new behavior*

1. Modeling: Modeling is a method of teaching by demonstration, wherein the therapist shows how a specific behavior is to be performed. In modeling the patient observes other patients indulging in target behaviors and getting rewards for those behaviors. This will make the patient repeat the same behavior and earn rewards in the same manner.
2. Shaping: In shaping the components of a particular skill, the behavior is reinforced step by step. The therapist starts shaping by reinforcing the existing behavior. Once it is established he reinforces the responses which are closest to the desired behavior, and ignores the other responses.

For example, to establish eye-to-eye contact, the therapist sits opposite the patient and reinforces him even if he moves his upper body towards him. Once this is established, he reinforces the person's head movement in his direction and this procedure continues till eye-to-eye contact is established.

3. Chaining: Chaining is used when a person fails to perform a complex task. The complex task is broken into a number of small steps and each step is taught to the patient. In forward chaining one starts with the first step, goes on to the second step, then to the third and so on. In backward chaining, one starts with the last step and goes on to the next step in a backward fashion. Backward chaining is found to be more effective in training the mentally disabled.

F. *Operant conditioning procedures for decreasing maladaptive behavior*

1. Extinction/Ignoring: Extinction means removal of attention rewards permanently, following a problem behavior. This includes actions like not looking at the patient, not talking to the patient, or having no physical contact with the patient etc, following the problem behavior.

This is commonly used when patient exhibits odd behavior.

2. Punishment: Aversive stimulus (punishment) is presented contingent upon the undesirable response. The punishment procedure should be administered immediately and consistently following the undesirable behavior with clear explanation.

Differential reinforcement of an adaptive or desirable behavior should always be added when a punishment is being used for decreasing an undesirable behavior. Otherwise the problem behaviors tend to get maintained because of the lack of adaptive behaviors and skill defect.

3. Timeout: Timeout method includes removing the patient from the reward or the reward from the patient for a particular period of time following a problem behavior. This is often used in the treatment of childhood disorders. For example, the child is not allowed to go out of the ward to play if he fails to complete the given work.
4. Restitution (Over-correction): Restitution means restoring the disturbed situation to a state that is much better than what it was before the occurrence of the problem behavior.

For example, if a patient passes urine in the ward he would be required to not only clean the dirty area but also mop the entire/larger area of the floor in the ward.

5. Response cost: This procedure is used with individuals who are on token programs for teaching adaptive behavior. When undesirable behavior occurs, a fixed number of tokens or points are deducted from what the individual has already earned.

G. *Assertiveness and social skill training:* Assertive training is a behavior therapy technique in which the patient is given training to bring about change in emotional and other behavioral pattern by being assertive. Client is encouraged not to be afraid of showing an appropriate response, negative or positive, to an idea or suggestion. Assertive behavior training is given by the therapist, first by role play and then by practice in a real life situation. Attention is focused on more effective interpersonal skills.

Social skills training helps to improve social manners like encouraging eye contact, speaking appropriately, observing simple etiquette, and relating to people.

### Cognitive Therapy

Cognitive therapy is a psychotherapeutic approach based on the idea that behavior is secondary to thinking. Our moods and feelings are influenced by our thoughts. Self-defeating and self-deprecating patterns of thinking result in depressed mood. The therapist helps the patient by correcting this distorted way of thinking, feelings and behavior.

The cognitive model of depression includes the cognitive triad:

1. A negative view about self
2. A negative view about the environment and
3. A negative view about the future

These negative thoughts are modified to improve the depressive mood. Cognitive therapy is used for the treatment of depression, anxiety disorder, panic disorder, phobic disorder and eating disorders.

### Hypnosis

The word 'hypnotism' was first used by James Braid in the 19th century. Hypnosis is an artificially induced state in which the person is relaxed and unusually suggestible. Hypnosis can be induced in many ways, such as by using a fixed point for attention, rhythmic monotonous instructions, etc.

### *Changes that occur during Hypnosis*

- The person becomes highly suggestible to the commands of the hypnotist.
- There is an ability to produce or remove symptoms or perceptions.
- Dissociation of a part of body or emotions .
- Amnesia for the events that occurred during the hypnotic state.

### *Techniques*

Patient is either made to lie down on a bed or sit in a chair. He is asked to gaze fixedly on a spot. Therapist makes monotonous suggestions of relaxation and sleep. The patient however is not asleep and can hear what is being said, answer questions and obey instructions.

This therapy is useful in:

- Abreaction of past experiences.
- Psychosomatic disorders.
- Conversion and dissociative disorders.
- Eating disorders.
- Habit disorders and anxiety disorders.

### **Abreaction Therapy**

Abreaction is a process by which repressed material, particularly a painful experience or conflict is brought back to consciousness. The person not only recalls but also relives the material, which is accompanied by the appropriate emotional response. It is most useful in acute neurotic conditions caused by extreme stress (Post-traumatic stress disorder, hysteria etc).

Although abreaction is an integral part of psychoanalysis and hypnosis, it can also be used independently.

### *Method*

Abreaction can be brought about by strong encouragement to relive the stressful events. The procedure is begun with neutral topics at first, and gradually approaches areas of conflict. Although abreaction can be done with or without the use of medication, the procedure can be facilitated by giving a sedative drug intravenously. A

safe method is the use of thiopentone sodium i.e. 500 mg dissolved in 10 cc of normal saline. It is infused at a rate no faster than 1 cc/minute to prevent sleep as well as respiratory depression.

### **Relaxation Therapies**

Relaxation produces physiological effects opposite those of anxiety: slowed heart rate, increased peripheral blood flow and neuromuscular stability.

There are many methods which can be used to induce relaxation.

### *Jacobson's Progressive Muscular Relaxation*

Patients relax major muscle groups in fixed order, beginning with the small muscle groups of the feet and working cephalad or vice versa.

### *Hypnosis*

### *Mental Imagery*

It is a relaxation method in which patients are instructed to imagine themselves in a place associated with pleasant relaxed memories. Such images allow patients to enter a relaxed state or experience a feeling of calmness and tranquility.

### *Use of Tape-recorded Exercises or Instructions*

Which allows patients to practice relaxation on their own.

### *Yoga or Meditation*

It is concentrating on the spirit by using certain postures to prepare the body to sit motionless, remain alert and focus on one particular point.

Yoga is highly useful in reducing stress and treating anxiety.

### *Bio-feedback*

Bio-feedback is based on the idea that the autonomic nervous system can come under voluntary control through operant conditioning. Thus it helps people to control usually involuntary physiological functions so as to change them, for

instance, by relaxing. People learn to control these functions by hearing or seeing signals from instruments that produce information about various measures such as muscle tension, blood pressure, etc. This feedback helps the patient to control such responses.

Uses of bio-feedback include treatment of enuresis, and treatment of a host of ailments brought on by stress such as migraine headaches, tension headaches, idiopathic hypertension, cardiac problems, etc.

### Individual Psychotherapy

Psychotherapy can be defined as the treatment for problems of an emotional nature, in which a trained person deliberately establishes a professional relationship with the patient to remove, modify or retard existing symptoms, mediate disturbed patterns of behavior and promote positive personality growth and development.

Individual psychotherapy is conducted on a one-to-one basis, i.e. the therapist treats one client at a time. The patient is encouraged to discover for himself the reasons for his behavior. The therapist listens to the patient and offers explanation and advice when necessary. By this he helps the patient to come to a greater understanding of himself and to find a way of dealing with his problems.

*Indications:* Stress-related disorders, alcohol and drug dependence, sexual disorders and marital disharmony.

### Supportive Psychotherapy

In this, the therapist helps the patient to relieve emotional distress and symptoms without probing into the past and changing the personality. He uses various techniques such as:

- *Ventilation:* It is a free expression of feelings or emotions. Patient is encouraged to talk freely whatever comes to his mind.
- *Environmental modification/manipulation:* Improving the well-being of mental patients by changing their living condition.
- *Persuasion:* Here the therapist attempts to modify the patient's behavior by reasoning.

- *Re-education:* Education to the patient regarding his problems, ways of coping, etc.
- *Reassurance*

### Group Therapy

Group psychotherapy is a treatment in which carefully selected people who are emotionally ill meet in a group guided by a trained therapist, and help one another effect personality change.

#### *Selection*

- Homogeneous groups
- Adolescents and patients with personality disorders
- Families and couples where the system needs change

#### *Contraindications*

- Antisocial patients
- Actively suicidal or severely depressed patients
- Patients who are delusional and who may incorporate the group into their delusional system

#### *Group Size*

Optimal size for group therapy is 8 to 10 members.

#### *Frequency and Length of Sessions*

Most group psychotherapists conduct group sessions once a week; each session may last for 45 minutes to 1 hour.

#### *Approaches to Group Therapy*

- The therapist's role is primarily that of a facilitator; he should provide a safe, comfortable atmosphere for self-disclosure
- Focus on the "here and now"
- Use any transference situations to develop insight into their problems
- Protect members from verbal abuse or from scapegoating
- Whenever appropriate, provide positive reinforcement, this gives ego support and encourages future growth

- Handle circumstantial patients, hallucinating and delusional patients in a manner that protects the self-esteem of the individual and also sets limits on the behavior so as to protect other group members
- Develop ability to recognize when a group member is "fragile"; he should be approached in a gentle, supportive and non-threatening manner
- Use silence effectively to encourage introspection and facilitate insight
- Laughter and a moderate amount of joking can act as a safety valve and at times can contribute to group cohesiveness
- Role-playing may help a member develop insight into the ways in which he relates to others

#### *Therapeutic Factors Involved in Group Therapy*

These involve sharing experiences, support to and from group members, socialization, imitation and interpersonal learning.

*Sharing experience:* This helps the patients to realize that they are not isolated and that others also have similar experiences and problems. Hearing from other patients that they have shared experiences is often more convincing and helpful than reassurance from the therapist.

*Support to and from group members:* Receiving help from other group members can be supportive to the person helped. The sharing action of being mutually supporting is an aspect of group cohesiveness that can provide a sense of belonging for patients who feel isolated in their everyday lives.

*Socialization:* It is acquisition of social skills (for e.g. maintaining eye contact) within a group through comments that members provide about one another's deficiencies in social skills. This process can be helped by trying out new ways of interacting within the safety of the group.

*Imitation:* It is learning from observing and adapting the behaviors of other group members.

If the group is run well, patients imitate the adaptive behaviors of other group members.

*Interpersonal learning:* It refers to learning about difficulties in relationships by examining the interaction of individuals with the other members of the group.

#### *Some Techniques Useful in Group Therapy*

- Reflecting or rewarding comments of group members
- Asking for group reaction to one member's statement
- Asking for individual reaction to one member's statement
- Pointing out any shared feelings within the group
- Summarizing various points at the end of session

In conclusion, one may say that group therapy plays a major role in the rehabilitation of the mentally ill individual. Group therapy gives an opportunity for immediate feedback from a patient's peer and a chance for both patient and therapist to observe the patient's psychological, emotional and behavioral response towards a variety of people. Thus it helps the patient to master communication and interpersonal skills, problem solving, decision making and assertiveness skills, thus enabling him to re-enter the society's mainstream with a greater degree of confidence.

#### **Psychodrama**

Psychodrama is a specialized type of group therapy that employs a dramatic approach in which patients become actors in life-situation scenarios. The goal is to resolve interpersonal conflicts in a less threatening atmosphere than the real-life situation would present.

In psychodrama the patient is brought directly into the situation as an active participant. The director co-ordinates the process so that the group and the protagonist receive maximal benefit. Other group members act as auxiliary egos and play the roles of significant others with whom relationships are being explored.

The primary advantage of psychodrama is its direct access to reenacting painful situations so that the painful emotions associated with them can be reworked, with the potential for spontaneously learning new responses in a safe therapeutic environment.

### **Family and Marital Therapy**

Family therapy is that branch of psychiatry which sees an individual's psychiatric symptoms as inseparably related to the family in which he lives. Thus the focus of treatment is not the individual, but the family. Today, most family theorists identify the individual's problems as a symptom of trouble within the family.

#### *Indications*

Family therapy is indicated whenever there are relational problems within a family or marital unit, which can occur in almost all types of psychiatric problems, including psychoses, reactive depression, anxiety disorders, psychosomatic disorders, substance abuse and various childhood psychiatric problems.

#### *Components of Therapy*

- Assessment of family structure, roles, boundaries, resources, communication patterns and problem solving skills
- Teaching communication skills
- Teaching problem solving skills
- Writing a behavioral marital contract
- Homework assignments

#### *Client Selection*

- Families may be referred for treatment by private physicians, and agencies such as the school system, welfare board, parole officers, and judges.
- Some families are referred for therapy from emergency room psychiatric services after a visit caused by a crisis in the family, such as a drug overdose.
- On discharge from a psychiatric hospital, a client and his family may be referred for family therapy, as part of follow up services.

- Family therapy is the treatment of choice when there is a marital problem or sibling conflict; family therapy may also be indicated when problems are caused by using one child as the scapegoat.
- Situational crises such as the sudden death of a family member, and maturational crises such as birth of the first child, may cause sufficient stress to warrant family therapy.

### **Types of Family Therapy**

#### *Individual Family Therapy*

In individual family therapy each family member has a single therapist. The whole family may meet occasionally with one or two of the therapists to see how the members are relating to one another and work out specific issues that have been defined by individual members.

#### *Conjoint Family Therapy*

The most common type of family therapy is the single-family group, or conjoint family therapy. The nuclear family is seen, and the issues and problems raised by the family are the ones addressed by the therapist. The way in which the family interacts is observed and becomes the focus of therapy. The therapist helps the family deal more effectively with problems as they arise and are defined.

#### *Couples Therapy*

Couples are often seen by the therapist together. The couple may be experiencing difficulties in their marriage, and in therapy they are helped to work together to seek a resolution for their problems. Family patterns, interaction and communication styles, and each partner's goals, hopes and expectations are examined in therapy. This examination enables the couple to find a common ground for resolving conflicts by recognizing and respecting each other's similarities and differences.

#### *Multiple Family Group Therapy*

In multiple family group therapy, four or five families meet weekly to confront and deal with

problems or issues they have in common. Ability or inability to function well in the home and community, fear of talking to or relating to others, abuse, anger, neglect, the development of social skills, and responsibility for oneself are some of the issues on which these groups focus. The multiple family group becomes the support for all the families. The network also encourages each person to reach out and form new relationships outside the group.

#### *Multiple Impact Therapy*

In multiple impact therapy, several therapists come together with the families in a community setting. They live together and deal with pertinent issues for each family member within the context of the group. Multiple impact therapy is similar to multiple family group therapy except that it is more intense and time-limited. Like multiple family group therapy, it focuses on developing skills or working together as a family and with other families.

#### *Network Therapy*

Network therapy is conducted in people's homes. All individuals interested or invested in a problem or crisis that a particular person or persons in a family are experiencing take part. This gathering includes family, friends, neighbors, professional groups or persons, and anyone in the community who has an investment in the outcome of the current crisis. People who form the network generally know each other and interact on a regular basis in each other's lives. Thus a network may include as many as 40 to 60 people.

The rewards are great when all the people involved mobilize energy for management of the problem. The power is in the network itself. The answers to each problem come from the network and how people in the network decide to manage each issue as it arises. The therapists serve as a guide to clarify issues, reinforce the importance of and need for the network toward its members collectively and individually, and assist in the

development and effective management in the evolution of the problem resolution.

#### **MILIEU THERAPY**

The therapeutic milieu is an environment that is structured and maintained as an ideal, dynamic setting in which to work with clients. This milieu includes safe physical surroundings, all the treatment team members, and other clients. It is supported by clear and consistently maintained limits and behavioral expectations.

A therapeutic setting should minimize environmental stress such as noise and confusion, and physical stress. It provides a chance for rest and nurturance of self, a time to focus on the development of strengths, and an opportunity to learn to identify alternatives or solutions to problems and to learn about the psychodynamics of those problems.

A therapeutic milieu is a "safe space," a non-punitive atmosphere in which caring is a basic factor. In this environment, confrontation may be a positive therapeutic tool that can be tolerated by the client. Nurses and treatment team members should be aware of their own roles in this environment, maintaining stability and safety, but minimizing authoritarian behavior. Clients are expected to assume responsibility for themselves within the structure of the milieu as much as possible. Feedback from other clients and the sharing of tasks or duties within the treatment program facilitate the client's growth.

The various components of therapeutic milieu include:

#### *Maintaining Safe Environment*

The nursing staff should follow the facility's policies with regard to prevention of routine safety hazards and supplement these policies as necessary. For example:

- Dispose of all needles safely and out of reach of clients.
- Restrict or monitor the use of matches and lighters.
- Do not allow smoking.

- Remove mouthwash, aftershave lotions and so forth, if substance abuse is suspected.
- Listed below are the most restrictive measures to be used on a unit on which clients who are exhibiting behavior directly threatening or harmful to themselves or others may be present. These measures may be modified based on the assessment of the client's behavior:
  - immediately on the client's admission, search the client and all of the client's belongings and remove potentially dangerous items, such as wire, clothes hangers, ropes, belts, safety pins, scissors and other sharp objects, weapons, and medications; keep these belongings in a designated place inaccessible to the client,
  - be sure mirrors, if glass, are securely fastened and not easily broken
  - keep sharp objects (e.g. scissors, pocket knives, knitting needles) out of reach of clients and allow their use only with supervision; use electric shavers when possible (disposable razors are easily broken to access blades)
  - identify potential weapons (e.g. mop handles, hammers) and dangerous equipment (e.g. electrical cords, scalpels), and keep them out of the client's reach
  - do not leave cleaning fluids, bleach, mops and tools, unattended in client care areas
  - do not leave medicines unattended or unlocked
  - keep keys (to unit door, medicines) on your person at all times
  - be aware of items that are harmful if ingested, for example, mercury in manometers
  - search packages brought in by visitors, explain the reason for such rules briefly, and do not make any exceptions

### *The Trust Relationship*

One of the keys to a therapeutic environment is the establishment of trust. Both the client and the nurse must trust that treatment is desirable and productive. Trust is the foundation of a

therapeutic relationship, and limit-setting and consistency are its building blocks.

### *Building Self-esteem*

Strategies to help build or enhance self-esteem must be individualized and built on honesty and on the client's strengths. Some general suggestions are:

- Set and maintain limits.
- Accept the client as a person.
- Be non-judgmental at all times.
- Structure the client's time and activities.
- Have realistic expectations of the client and make them clear to the client.
- Initially provide the client with tasks, responsibilities and activities that can be easily accomplished; advance the client to more difficult tasks as he progresses.
- Praise the client for his accomplishments however small, giving sincere appropriate feedback for meeting expectations, completing tasks, fulfilling responsibilities, and so on.
- Never flatter the client.
- Use confrontation judiciously and in a supportive manner; use it only when the client can tolerate it.
- Allow the client to make his own decisions whenever possible. If the client is pleased with the outcome of his decision, point out that he was responsible for the decision and give positive feedback.
- If the client is not pleased with the outcome, point out that the client like everyone can make and survive mistakes, then help the client identify alternative approaches to the problem; give positive feedback for the client's taking responsibility for problem solving and for his efforts.

### *Limit-setting*

Setting and maintaining limits are integral to a trust relationship and to a therapeutic milieu. Before stating a limit explain the reasons for limit-setting. Some basic guidelines for effectively using limits are:

- State the expectations or the limit as clearly, directly and simply as possible.
- The consequence that will follow the client's exceeding the limit also must be clearly stated at the outset.
- The consequences should immediately follow the client's exceeding the limit and must be consistent, both over time (each time the limit is exceeded) and among staff (each staff member must enforce the limit).
- Consequences are essential to setting and maintaining limits, they are not an opportunity to be punitive to a client.

In conclusion, the nurse works with other health professionals in an interdisciplinary team; The interdisciplinary team works within a milieu that is constructed as a therapeutic environment, with the aim of developing a holistic view of the client and providing effective treatment.

### THERAPEUTIC COMMUNITY

The concept of therapeutic community was first developed by Maxwell Jones in 1953. He wrote a book entitled "Social Psychiatry" which was first published in England. Later on when it was published in the United States, its title was changed to "Therapeutic Community."

#### Definition

Stuart and Sundeen defined therapeutic community as "a therapy in which patient's social environment would be used to provide a therapeutic experience for the patient by involving him as an active participant in his own care and the daily problems of his community."

#### Objectives

- To use patient's social environment to provide a therapeutic experience for him.
- To enable the patient to be an active participant in his own care and become involved in daily activities of his community.
- To help patients to solve problems, plan activities and to develop the necessary rules and regulations for the community.

- To increase their independence and gain control over many of their own personal activities.
- To enable the patients become aware of how their behavior affects others.

#### Elements of Therapeutic Community

- Free communication
- Shared responsibilities
- Active participation
- Involvement in decision making
- Understanding of roles, responsibilities, limitations and authorities

#### Components of Therapeutic Community

##### Daily Community Meetings

- These meetings are composed of 60-90 patients. All levels of unit staff are involved, including administrative personnel. Acute patients are not involved in the meetings.
- Meetings should be held regularly for 60 minutes.
- Discussion should focus mainly on day-to-day life in the unit.
- During discussions patients' feelings and behaviors are examined by other members.
- Frank discussions are encouraged, these may take place with much outpouring of emotions and anger

##### Patient Government or Ward Council

- The purpose of patient government is to deal with practical unit details such as house-keeping functions, activity planning and privileges.
- A group of 5-6 patients will have specific responsibilities, such as house keeping, physical exercise, personal hygiene, meal distribution, a group to observe suicidal patients, etc. Staff members should be available always.
- All decisions should be feedback to the community through the community meetings

##### Staff Meetings or Review

A staff meeting should be held following each community meeting (Patients are excluded and

only staff are present). In this meeting the staff would examine their own responses, expectations, and prejudices.

### *Living and Learning Opportunities*

Learning opportunities are to be provided within the social milieu, which should provide realistic learning experiences for the patients.

### **Advantages of Therapeutic Community**

- Patient develops harmonious relationships with other members of the community.
- Gains self-confidence.
- Develops leadership skills.
- Learns to understand and solve problems of self and others.
- Becomes socio-centric.
- Learns to live and think collectively with the members of the community.
- Lastly therapeutic community provides opportunities to participate in the formulation of hospital rules and regulations that affect patient's personal liberties like bedtime, meal time, weekend permission, control of radio or TV, social activities, late night privileges, etc.

### **Disadvantages of Therapeutic Community**

- Role blurring between staff and patient.
- Group responsibility can easily become nobody's responsibility.
- Individual needs and concerns may not be met.
- Patient may find the transition to community difficult

### **Role of the Nurse**

- Providing and maintaining a safe and conflict free environment through role modeling and group leadership.
- Sharing of responsibilities with patients .
- Encouraging patient to participate in decision-making functions.
- Assisting patients to assume leadership roles.
- Giving feedback.
- Carrying out supervisory functions.

In conclusion, therapeutic community is an approach which is:

- Democratic as opposed to hierachial.
- Rehabilitative rather than custodial.
- Permissive instead of limited and controlled.

### **ACTIVITY THERAPY**

Activity therapies include occupational therapy, recreational therapy, educational therapy, play therapy, music therapy, dance therapy, and art therapy.

### **Aims**

- To assist the client in making a transition from sick role to becoming a contributing member of society.
- To assist in diagnostic and personality evaluation.
- To enhance psychotherapy and other psychotherapeutic measures (the activity prescribed for the client often provides a nonverbal means for the client to express and resolve his feelings).

### **Occupational Therapy**

Occupational therapy is the application of goal-oriented, purposeful activity in the assessment and treatment of individuals with psychological, physical or developmental disabilities.

#### **Goal**

The main goal is to enable the patient to achieve a healthy balance of occupations through the development of skills that will allow him to function at a level satisfactory to himself and others.

#### **Settings**

Occupational therapy is provided to children, adolescents, adults and elderly patients. These programs are offered in psychiatric hospitals, nursing homes, rehabilitation centers, special schools, community group homes, community mental health centers, day care centers, halfway homes and deaddiction centers.

### **Advantages**

- Helps to develop social skills and provide an outlet for self-expression.
- Strengthens ego defenses.
- Develops a more realistic view of the self in relation to others.

### **Points to be Kept in Mind**

- The client should be involved as much as possible in selecting the activity.
- Select an activity that interests or has the potential to interest him.
- The activity should utilize the client's strengths and abilities.
- The activity should be of short duration to foster a feeling of accomplishment.
- If possible, the selected activity should provide some new experience for the client.

### **Process of Intervention**

It consists of six stages:

1. Initial evaluation of what patient can do and cannot do in a variety of situations over a period of time.
2. Development of immediate and long-term goals by the patient and therapist together. Goals should be concrete and measurable so that it is easy to see when they have been attained.
3. Development of therapy plan with planned intervention.
4. Implementation of the plan and monitoring the progress. The plan is followed until the first evaluation. If satisfactory it is continued, or altered if not.
5. Review meetings with patient and all the staff involved in treatment.
6. Setting further goals when immediate goals have been achieved; modifying the treatment program as relevant.

### **Types of Activities**

*Diversional activities:* These activities are used to divert one's thoughts from life stresses or to fill time.

For example, organized games.

*Therapeutic activities:* These activities are used to attain a specific care plan or goal.

For example, basket making, carpentry, etc.

### **Suggested Occupational Activities for Psychiatric Disorders**

*Anxiety disorder* Simple concrete tasks with no more than 3 or 4 steps that can be learnt quickly. For example, kitchen tasks, washing, sweeping, mopping, mowing lawn and weeding gardens.

*Depressive disorder* Simple concrete tasks which are achievable; it is important for the client to experience success. Provide positive reinforcement after each achievement.

For example, crafts, mowing lawn, weeding gardens.

*Manic disorder* Non-competitive activities that allow the use of energy and expression of feelings. Activities should be limited and changed frequently. Client needs to work in an area away from distractions.

For example, raking grass, sweeping, etc.

*Schizophrenia (paranoid)* Non-competitive, solitary meaningful tasks that require some degree of concentration so that less time is available to focus on delusions.

For example, puzzles, scrabble.

*Schizophrenia (catatonic)* Simple concrete tasks in which client is actively involved. Client needs continuous supervision, and at first works best on a one-to-one basis.

For example, metal work, molding clay, etc.

*Antisocial personality* Activities that enhance self-esteem and are expressive and creative, but not too complicated. Client needs supervision to make sure each task is completed.

*Dementia* Group activities to increase feeling of belonging and self-worth. Provide those activities which promote familiar individual hobbies. Activities need to be structured, requiring little time for completion and not much concentration. Explain and demonstrate each task, then have client repeat the demonstration.

**Substance abuse** Group activities in which client uses his talents. For example, involving client in planning social activities, encouraging interaction with others, etc.

### *Childhood and adolescent disorders*

**Children:** Playing, story telling, painting, poetry, music, etc.

**Adolescents:** Creative activities such as leather work, drawing, painting.

**Mental retardation** Repetitive work assignments are ideal; provide positive reinforcement after each achievement.

For example, cover making, candle making, packaging goods, etc.

### **Recreational Therapy**

Recreation is a form of activity therapy used in most psychiatric settings. It is a planned therapeutic activity that enables people with limitations to engage in recreational experiences.

#### **Aims**

- To encourage social interaction.
- To decrease withdrawal tendencies.
- To provide outlet for feelings.
- To promote socially acceptable behavior.
- To develop skills, talents and abilities.
- To increase physical confidence and a feeling of self worth.

#### **Points to be Kept in Mind**

- Provide a non-threatening and non-demanding environment.
- Provide activities that are relaxing and without rigid guidelines and time-frames.
- Provide activities that are enjoyable and self-satisfying.

#### **Types of Recreational Activities**

**Motor forms:** These can be further divided into fundamental and accessory; among the fundamental forms are such games as hockey and football, while the accessory forms are exemplified by play activity and dancing.

**Sensory forms:** These can be either visual, e.g. looking at motion pictures, play, etc., or auditory such as listening to a concert.

**Intellectual forms:** These include reading, debating and so on.

#### *Suggested Recreational Activities for Psychiatric Disorders*

**Anxiety disorders** Aerobic activities like walking, jogging, etc.

**Depressive disorder** Non-competitive sports, which provide outlet for anger, like jogging, walking, running, etc.

**Manic disorder** One-to-one basis individual games like badminton, ball.

**Schizophrenia (paranoid)** Concentrative activities like chess, puzzles.

**Schizophrenia (catatonic)** Social activities to give client contact with reality, like dancing, athletics.

**Dementia** Concrete, repetitious crafts and projects that breed familiarization and comfort.

**Childhood and adolescent disorders** It is better to work with the child on a one-to-one basis and give him a feeling of importance. Some activities include playing, story telling, and painting.

Adolescents fare better in groups; provide gross motor activities like sports and games to use up excess energy.

**Mental retardation** Activities should be according to the client's level of functioning such as walking, dancing, swimming, ball playing, etc.

### **Educational Therapy**

Educational therapy is used when the client has problems which result from a great deal of misconception. The educational therapist provides reading and learning experiences that can do a great deal to eliminate his misconceptions and anxiety.

### Biblio Therapy

It is described as the prescription of reading materials that will help to develop emotional maturity and sustain mental health.

Some emotionally disturbed individuals are able to relate therapeutically to the experiences of others when they read about them, rather than experiencing them directly. It also provides a medium for discussion with others.

### Play Therapy

Play is a natural mode of growth and development in children. Through play a child learns to express his emotions and it serves as a tool in the development of the child.

#### *Curative Functions*

- It releases tension and pent-up emotions.
- It allows compensation for loss and failures.
- It improves emotional growth through his relationship with other children.
- It provides an opportunity to the child to act out his fantasies and conflicts, to get rid of aggression and to learn positive qualities from other children.

#### *Diagnostic Functions*

- Play therapy gives the therapist a chance to explore family relationships of the child and discover what difficulties are contributing to the child's problems.
- Play therapy allows to study hidden aspects of the child's personality.
- It is possible to obtain a good idea of the intelligence level of the child.
- Through play inter-sibling relationships can be adequately studied

#### *Types of Play Therapy*

*Individual vs Group play therapy* In individual therapy the child is allowed to play by himself and the therapist's attention is focused on this one child alone.

In group play therapy other children are involved.

*Free play vs Controlled play therapy* In free play the child is given freedom in deciding with what toys he wants to play.

In controlled play therapy, the child is introduced into a scene where the situation or setting is already established.

*Structured vs Unstructured play therapy* Structured play therapy involves organizing the situation in such a way so as to obtain more information.

In unstructured play therapy no situation is set and no plans are followed.

*Directive vs Non-directive play therapy* In directive play therapy, the therapist totally sets the directions, whereas in non-directive play therapy, the child receives no directions.

Play therapy is generally conducted in a playroom. The playroom should be suitably stocked with adequate play material, depending upon the problems of the child.

### Music Therapy

Music therapy is the functional application of music towards the attainment of specific therapeutic goals.

#### *Advantages*

- Facilitates emotional expressions .
- Improves cognitive skills like learning, listening and attention span.
- Social interaction is stimulated.

### Dance Therapy

It is a psychotherapeutic use of movement, which furthers the emotional and physical integration of the individual.

#### *Advantages*

- Helps to develop body awareness.
- Facilitates expression of feelings.
- Improves interaction and communication.
- Fosters integration of physical, emotional and social experiences that result in a sense of increased self-confidence and contentment.
- Exercise through body movement maintains good circulation and muscle tone.

### Art Therapy

The goal of art therapy is to help the patient express his thoughts, emotions, and feelings through his drawings.

#### *Importance of Art Therapy*

- It is used as a diagnostic and therapeutic tool.
- It provides socially acceptable outlet for fantasy and wish fulfillment.
- It helps the patient to gain relief from anxiety by graphically representing conflict and aggressive and traumatic material without guilt.

### **Implications of Activity Therapies for Nursing Practice**

The nurse has an important role in enhancing the therapeutic effects of activity therapies. Some points to be kept in mind are:

- Close coordination between the nursing staff and the activity therapy department is essential.
- By engaging in these activities, the nurse not only has an opportunity to support the therapeutic efforts of the recreational therapist but also has an invaluable opportunity to observe the client in different settings.
- Through her observations of the client's behavior during these activities, the nurse will gain valuable information that she can subsequently utilize to therapeutic advantage in the working phase of the nurse-client relationship.

### **REVIEW QUESTIONS**

- Classification of psychotropic drugs (Feb 2001)
- Classification of antipsychotic drugs
- Role of a nurse in administration of psychotropic drugs (Nov 1999)
- EPS (Oct 2000, Nov 2001, Nov 2003)
- Drug induced parkinsonism
- Akathesia (Apr 2004)
- Dystonia (Oct 2006)

- Neuroleptic malignant syndrome
- Anti psychotic drugs (Oct 2004)
- Atypical anti psychotics (Apr 2006)
- Mood stabilizing drugs (Nov 2001, Nov 2003)
- Lithium (Nov 1999, Apr 2004, Oct 2004, Oct 2005)
- Antidepressants (Apr 2006)
- Benzodiazepines
- Drugs used in treatment of anxiety (Apr 2006)
- Electroconvulsive therapy (Feb 2000, Apr 2006, Oct 2006)
- Pre ECT preparation (Apr 2006)
- Post ECT care (Nov 2002, Nov 2003)
- Complications of ECT (Oct 2002, Oct 2005)
- Role of a nurse in ECT management (Nov 1999, Apr 2004)
- Psychological therapies (Nov 1999, Apr 2006)
- Psychoanalytical therapy (Nov 2003)
- Dream analysis (Nov 2003, Oct 2004)
- Behavior therapy (Feb 2000, Nov 2003)
- Systematic desensitization
- Aversion therapy (Oct 2000)
- Token economy (Nov 2001)
- Hypnosis (Nov 2002, Nov 2003)
- Abreaction therapy (Oct 2000)
- Narco-analysis (Oct 2005)
- Supportive psychotherapy
- Individual psychotherapy (Oct 2005)
- Family therapy (Apr 2002, Oct 2002, Oct 2005, Oct 2006)
- Group therapy (Feb 2001, Apr 2002, Apr 2006)
- Psychodrama (Nov 2002)
- Recreation therapy (Apr 2002, Apr 2006)
- Play therapy (Nov 2002, Nov 2003, Apr 2004, Oct 2005)
- What are the characteristics of a therapeutic environment? How will you create such an environment in a psychiatric unit? (Feb 2000)
- Milieu therapy (Oct 2005)
- Therapeutic community (Nov 1999, Nov 2002, Nov 2003, Oct 2004, Apr 2006)
- Activity therapy (Oct 2000)
- Social skill training (Nov 2003)
- Occupational therapy (Nov 1999, Feb 2001, Nov 2002, Nov 2003, Oct 2006)

# 15

## Crisis Intervention

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### GRIEF

Grief is a subjective state of emotional, physical and social response to the loss of a valued entity. The loss may be real, in which case it can be substantiated by others (e.g. death of a loved one), or perceived by the individual alone, in which case it cannot be perceived or shared by others (e.g. loss of feeling of femininity following mastectomy).

#### Stages of Grief

Kubler-Ross (1969) having done extensive research with terminally ill patients identified five stages of feelings and behavior that individuals experience in response to a real, perceived or anticipated loss:

*Stage I—Denial:* This is a stage of shock and disbelief. The response may be one of “No, it can’t be true!” Denial is a protective mechanism that allows the individual to cope within an immediate time-frame while organizing more effective defense strategies.

*Stage II—Anger:* “Why me?” and “It is not fair!” are comments often expressed during the anger stage. Anger may be directed at self or displaced on loved ones, caregivers, and even God. There may be a preoccupation with an idealized image of the lost entity.

*Stage III—Bargaining:* “If God will help me through this, I promise I will go to church every Sunday and volunteer my time to help others”. During this stage, which is generally not visible or evident to others, a bargain is made with God in an attempt to reverse or postpone the loss.

*Stage IV—Depression:* During this stage the full impact of the loss is experienced. This is a time of quiet desperation and disengagement from all associations with the lost entity.

*Stage V—Acceptance:* The final stage brings a feeling of peace regarding the loss that has occurred. Focus is on the reality of the loss and its meaning for the individuals affected by it.

All individuals do not experience each of these stages in response to a loss, nor do they necessarily experience them in this order. Some individuals grieving behavior may fluctuate, and even overlap between stages.

### **Resolution of Grief**

Resolution of the process of mourning is thought to have occurred when an individual can look back on the relationship with the lost entity and accept both the pleasure and the disappointments (both the positive and negative aspects) of the association. Pre-occupation with the lost entity is replaced with energy and desire to pursue new situations and relationships.

The length of the grief process may be prolonged by a number of factors:

If the relationship with the lost entity had been marked by ambivalence, reaction to the loss may be burdened with guilt, which lengthens the grief reaction.

In anticipatory grief where a loss is anticipated, individuals often begin the work of grieving before the actual loss occurs. Most people experience the grieving behavior once the actual loss occurs, but having this time to prepare for the loss can facilitate the process of mourning, actually decreasing the length and intensity of the response.

The number of recent losses experienced by an individual also affects the length of the grieving process and whether he is able to complete one grieving process before another loss occurs.

### **Maladaptive Grief Responses**

Maladaptive grief responses to loss occur when an individual is not able to satisfactorily progress through the stages of grieving to achieve resolution. Several types of grief responses have been identified as pathological [Lindemann (1944), Parkes (1972)].

These are prolonged, delayed/inhibited, and distorted responses.

#### *Prolonged Response*

It is characterized by an intense preoccupation with memories of the lost entity for many years after the loss has occurred.

#### *Delayed or Inhibited Response*

The individual becomes fixed in the denial stage

of the grieving process. The emotional pain associated with loss is not experienced, but there may be evidence of anxiety disorders or sleeping disorders. The individual may remain in denial for many years until the grief response is triggered by a reminder of the loss or even by another unrelated loss.

#### *Distorted Response*

The individual who experiences a distorted response is fixed in the anger stage of grieving. The normal behaviors associated with grieving, such as helplessness, hopelessness, sadness, anger and guilt are exaggerated out of proportion to the situation. The individual turns the anger inward on the self and is unable to function in normal activities of daily living. Pathological depression is a distorted grief response.

### **Treatment**

Normal grief does not require any treatment while complicated grief requires medication depending on the prevailing behavior responses.

### **Nursing Intervention**

- Provide an open accepting environment.
- Encourage ventilation of feelings and listen actively.
- Provide various diversional activities.
- Provide teaching about common symptoms of grief.
- Reinforce goal-directed activities.
- Bring together similar aggrieved persons, to encourage communication, share experiences of the loss and to offer companionship, social and emotional support.

### **CRISIS**

Crisis can be viewed as an integral component of everyday life situations. A crisis may influence people's lives in different ways. As a consequence of a crisis experience, the individual may go down to a lower or less healthy level of functioning than what was before the crisis, or he may resume the same level of functioning by repressing the

crisis and the related emotions. On the other hand, he may function at a healthier level than prior to the crisis, because the challenge of a crisis can bring out new strengths, skills and coping mechanisms.

Intervention at a crisis is extremely important to prevent mental illness, because long-standing problems make the person totally incapable of handling the situation. If proper guidance is provided at the correct time, the victim will come out of it better equipped to handle future problems in life.

### **Definition**

Crisis is a state of disequilibrium resulting from the interaction of an event with the individual's or family's coping mechanisms, which are inadequate to meet the demands of the situation, combined with the individual's or family's perception of the meaning of the event (Taylor 1982).

### **Crisis Proneness**

Hendricks (1985) suggests that certain individuals are more prone to crisis than others. The following are characteristics often found in individuals who are regarded as being more susceptible to crisis:

- Dissatisfaction with employment or lack of employment.
- History of unresolved crisis.
- History of substance abuse.
- Poor self-esteem, unworthiness.
- Superficial relationship with others.
- Difficulty in coping with everyday situations.
- Under utilization of resources and support systems.
- Aloofness and lack of caring.

It is important to note that individual personality traits must also be considered in conjunction with these characteristics. Crisis is defined by the individual; what is a crisis for one is merely an occurrence for another. This factor is a critical component that must be evaluated in

relation to crisis prone characteristics as well as personality traits.

### **Types of Crisis**

#### *Maturational Crisis*

A maturational crisis is a stage in a person's life where adjustment and adaptation to new responsibilities and life patterns are necessary.

The transition points where individuals move into successive stage often generate disequilibrium. Individuals are required to make cognitive and behavioral changes and to integrate those physical changes that accompany development.

The extent to which individuals experience success in the mastery of these tasks depends on previous successes, availability of support systems, influence of role models and acceptability of new role by others.

The transitional periods or events that are most commonly identified as having increased crisis potential are adolescence, marriage, parenthood, midlife and retirement.

#### *Situational Crisis*

A situational crisis is one that is precipitated by an unanticipated stressful event that creates disequilibrium by threatening one's sense of biological, social or psychological integrity.

Examples of events that can precipitate situational crises are premature birth, status and role changes, death of a loved one, physical or mental illness, divorce, change in geographic location and poor performance in school.

#### *Social Crisis*

Social crisis is accidental, uncommon, and unanticipated and results in multiple losses and radical environmental changes. Social crises include natural disasters like floods, earthquakes, violence, nuclear accidents, mass killings, contamination of large areas by toxic wastes, wars, etc. This type of crisis is unlike maturational and situational crisis because it does not occur in the lives of all people.

Because of the severity of the effects of social crisis coping strategies may not be effective. Individuals confronted with social crisis usually do not have previous experience from which to draw expertise. Support systems may be unavailable because they may also be involved in similar situations. Mental health professionals are called upon to act quickly and provide services to large numbers of people and in some cases, the whole community.

### **Phases of Crisis**

Caplan (1964) has described four phases of crisis as described below:

#### *Phase I*

Perceived threat acts as a precipitant that generates increased anxiety. Normal coping strategies are activated, and if unsuccessful, the individual moves into Phase II.

#### *Phase II*

The ineffectiveness of the Phase I coping mechanisms leads to further disorganization. The individual experiences a sense of vulnerability. The individual may attempt to cope with the situation in a random fashion. If the anxiety continues and there is no reduction, the individual enters Phase III.

#### *Phase III*

Redefinition of the crisis is attempted and the individual is most amenable to assistance in this phase. New problem solving measures may also affect a solution. Return to pre-crisis level of functioning may occur. If problem solving is unsuccessful, further disorganization occurs and the individual is said to have entered Phase IV.

#### *Phase IV*

Severe to panic levels of anxiety with profound cognitive, emotional and physiological changes may occur. Referral to further treatment resources is necessary.

### **Signs and Symptoms of Crisis**

- The major feeling in a crisis situation is anxiety. The individual experiences a heavy burden of free-floating anxiety.
- The anxiety may be manifested through depression, anger and guilt. The victim will attempt to get rid of the anxiety using various coping mechanisms, healthy or unhealthy.
- The individual may become incapable of even taking care of his daily needs and may neglect his responsibilities.
- The individual may become irrational and blame others for what has happened to him .

### **Resolution of Crisis**

Healthy resolution of a crisis depends upon the following three factors:

1. Realistic appraisal of the precipitating event, i.e. recognition of the relationship between the event and feelings of anxiety is necessary for effective problem-solving to occur.
2. Availability of support systems.
3. Availability of coping measures over a lifetime: A person develops a repertoire of successful coping strategies that enable him to identify and resolve stressful situations.

There are three ways by which the individual may resolve the crisis:

#### *Pseudo-resolution*

In this, the individual uses repression and pushes out of consciousness the incident and the intense emotions associated with it, so there will not be any change in the level of functioning of the individual. But in future, if and when a crisis occurs, the repressed feelings may surface and influence the feelings aroused by the new crisis. In such a situation, the particular crisis may be more difficult to resolve because the feelings associated with the earlier crisis are neither expressed nor handled at that time.

#### *Unsuccessful Resolution*

In this, the victim uses pathological adaptation at any phase of crisis, resulting in a lower level of

functioning. The victim, rather than accepting the loss and reorganizing his life, keeps ruminating over the loss. An example is prolonged grief reaction, which results in depression.

### ***Successful Resolution***

In this, the victim may go through the various phases of crisis, but reaches Phase III where various coping measures are utilized to resolve the crisis situation. The individual develops better skills and problem solving ability, which can be and will be used in various crisis situations in future.

### **Crisis Intervention**

Crisis intervention is a technique used to help an individual or family to understand and cope with the intense feelings that are typical of a crisis. Nurses function as part of the interdisciplinary team in the use of crisis intervention as a therapeutic modality. Nurses may employ crisis techniques in their work with high-risk groups such as clients with chronic diseases, new parents and bereaved persons.

Nurses may also use crisis intervention in dealing with intra-group staff issues and client management issues.

### ***Aims of Crisis Intervention Technique***

- To provide a correct cognitive perception of the situation.
- To assist the individual in managing the intense and overwhelming feelings associated with the crisis.

### ***Intervention***

#### ***A. Steps to provide a correct cognitive perception***

##### ***Assessment of the situation***

- This may be achieved by direct questioning with the purpose of identification of the problem and the people involved.
- It is necessary to identify the support systems available and to know the depth in which the individual's feelings are affected.

- Assessment should also be done to identify the strengths and limitations of the victim.

##### ***Defining the event***

- The victim at times may not be able to identify the precipitating event because of possible denial, or due to reluctance to talk about it.
- It may be necessary for the therapist to review the details of the incidents in the past 2 to 4 weeks in order to identify the event that precipitated the crisis. Such a review will help the victim becoming aware of the precipitating event.

##### ***Develop a plan of action***

- The victim and the people closely associated with him should have active involvement in developing the plan of action.
- The therapist must be aware that the victim may not be in a condition to mentally comprehend complicated information due to the overwhelming anxiety experienced by him. The instructions given by the therapist must be simple and clear, and too much information should not be given at a time. The instructions may have to be written down, as the victim may not be able to retain all the information.

#### ***B. Steps to assist the victim in managing the intense feelings***

##### ***Helping the individual to be aware of the feelings***

- The victim needs help in identifying his own feelings, which is the first step in handling them.
- The therapist should use appropriate communication technique so that the victim will feel comfortable to express his feelings without the fear of being judged or criticized.
- The therapist should also be efficient in observing verbal and non-verbal behavior of the victim, so that he will be able to make a careful assessment of his feelings.

##### ***Help the individual to attain mastery over the feelings***

- The individual should be given adequate support and guidance through therapeutic

process in order to handle feelings associated with crisis but special care should be taken not to give any false reassurance.

- He should not in any way be encouraged to blame others, as this will only let him escape from taking any responsibility.
- Care must be taken to ensure that the individual does not develop too much dependency on the therapist, which is unhealthy.
- After the victim and the support groups prepare the plan of action under the guidance of the therapist, it should be discussed with the victim and the concerned others, so that they will have a clear understanding of the methods of implementation of the plan.
- To improve coping with the situation necessary environmental manipulation must be done in physical or interpersonal areas.
- It is advisable to have another appointment for the victim to visit the therapist within a week, in order to assess how the plan is working out, and if needed, to revise and modify the plan.

### ROLE OF A NURSE IN CRISIS INTERVENTION

Nurses respond to crisis situations on a daily basis. Crisis can occur in any unit for e.g. in general hospitals, home settings, community health centers, schools, offices, and in private practice. Indeed, nurses may be called upon to function as crisis helpers in any situation.

Knowledge of crisis intervention techniques is thus an important clinical skill of all nurses, regardless of the setting or practice specialty.

### Nursing Assessment

The first step of crisis intervention is assessment. During this phase the nurse collects data regarding the following factors:

- Precipitating event or stressor
- Patient's perception of the event or stressor
- Nature and strength of the patient's support systems, coping resources
- Level of psychological stress patient is suffering from and the degree of impairment he is experiencing

- Patient's previous strengths and coping mechanisms

During this phase the nurse begins to establish a positive working relationship with the patient.

### Nursing Diagnoses

The primary nursing diagnoses in crisis intervention are:

- Ineffective individual coping
- Ineffective family coping
- Altered family process
- Post trauma response
  - Ineffective individual coping refers to the inability to ask for help, problem solving or meet role expectations
  - Ineffective family coping occurs when the family's support systems are not successful and family's economic or social well being is threatened
  - Altered family processes result when family members are unable to adapt to the traumatic experience constructively
  - Post-traumatic response is a sustained painful response to an overwhelming traumatic event.

### Planning

In planning the previously collected data is analyzed and specific interventions are proposed. During this phase the nurse will undertake the following activities:

- Dynamics underlying the present crisis are formulated
- Alternative solutions to the problem are explored
- Steps for achieving the solutions are identified
- Environmental support needed to help the patient is decided upon, coping mechanisms that need to be developed and those which need to be strengthened are identified

### Implementation

The following interventions are carried out to resolve crisis:

### *Environmental Manipulation*

Environmental manipulation includes interventions that directly change the patient's physical or interpersonal situation. These interventions may remove stress or provide situational support. For example a patient having difficulty in his job may take a week of sick leave so that he can be removed temporarily from that stress.

### *General Support*

The nurse uses warmth, acceptance, empathy and reassurance to provide general support to the patient.

### *Generic Approach*

The generic approach is designed to reach high risk individuals and large groups as quickly as possible. It applies a specific method to all individuals faced with a similar type of crisis (e.g. in social disasters). Debriefing is a method of generic approach. In debriefing method, disaster victims are helped to recall events and clarify traumatic experiences. It attempts to place the traumatic event in perspective, allows the individual to relive the event in a factual way, encourages group support, and provides information on normal reaction to critical events. The goal of debriefing is to prevent the maladaptive responses that may result if the trauma is suppressed.

### *Individual Approach*

The individual approach is a type of crisis intervention similar to the diagnosis and treatment of a specific problem in a specific patient. It is particularly useful in combined situational and maturational crises and also beneficial when symptoms include homicidal and suicidal risk. The nurse must use the intervention that is most likely to help the patient develop an adaptive response to the crisis.

### **Techniques of Crisis Intervention**

1. *Catharsis:* The release of feelings that takes place as the patient talks about emotionally charged areas.

2. *Clarification:* Encouraging the patient to express more clearly the relationship between certain events.
3. *Manipulation:* Using the patient's emotions, wishes or values to benefit the patient in the therapeutic process.
4. *Reinforcement of behavior:* Giving the patient positive reinforcement to adaptive behavior.
5. *Support of defenses:* Encouraging the use of healthy, adaptive defenses and discouraging those that are unhealthy or maladaptive.
6. *Increasing self-esteem:* Helping the patient to regain feelings of self worth.
7. *Exploration of solutions:* Examining alternative ways of solving the immediate problem.

### **Evaluation**

The nurse and patient review the changes that have occurred. The nurse should give credit for successful changes to patients so that they realize their effectiveness and understand that what they learnt from crisis may help in coping with future crisis. If the goals have not been met, the patient and nurse can return to the first step- assessment and continue through the phases again.

### **MODALITIES OF CRISIS INTERVENTION**

Community-based crisis intervention modalities have recently been developed. They are based on the philosophy that the health care team must be active and go out to the patients rather than wait for the patients to come to them. Nurses working in these modalities intervene in a variety of community settings, ranging from patients homes to street corners.

### **Mobile Crisis Programs**

Mobile crisis teams provide front-line interdisciplinary crisis intervention to individuals, families and communities. The nurse, who is a member of a mobile crisis team, should be able to provide on-site assessment, crisis management, treatment, referral and educational services to patients, families and the community at large. Nurses are thus able to ensure mental health care for even

the most under-served populations efficiently and cost effectively.

### Telephone Contacts

Crisis intervention is sometimes practiced by telephone rather than through face-to-face contacts. The nurse should have effective listening skills to provide crisis intervention to victims.

### Group Work

People who have common traits on stressors will form a group. The group provides an opportunity for members to express common concerns and experiences, foster hope and build mutual support. The nurse's role in the group is active, focal and focused on the present. The nurse and the group help the patient solve the problem and reinforce new problem solving behavior.

### Disaster Response

As part of the community, nurses are called on when an adventitious or social crisis strikes the community. Floods, earthquakes, airplane crashes, fires, nuclear accidents etc. precipitate large number of crises. The nurse has an important role in dealing with psychosocial problems of disaster victims. The nurse participates in crisis operations and acts as a case-finder for persons suffering from psychosocial stress. It is important that nurses in the immediate post disaster period go to places where victims are likely to gather, such as hospitals, shelters, morgues. During this period nurses use the generic approach of crisis intervention so that as many people as possible can receive help in a short duration of time.

### Victim Outreach Programs

Victim outreach programs use crisis intervention techniques to identify the needs of victims and then to connect them with appropriate referrals and other resources.

Nurses often work in victim outreach programs, where victims are often seen immediately after the crisis. These victims need thorough

evaluation, empathic support, and information and help with the large system and social networking system.

### Crisis Intervention Centers

Crisis intervention centers provide emergency psychiatric care and counseling to victims, experiencing extreme stress or conflict, often involving suicide attempts or drug or alcohol abuse. These centers, which are usually self-contained units within a hospital or community health care center, provide services 24 hours a day. The services may be delivered directly on the premises, or counseling may be provided over the telephone. The primary objective of crisis intervention centers is to help the person cope with immediate problem and to offer guidance and support for long-term therapy.

### Health Education

Nurses are involved in identifying people who are at high risk for developing crisis and in teaching coping strategies to avoid the development of crisis. The public also needs education so that they can identify those needing crisis services, be aware of available services, change their attitude so that people will feel free to seek services, and obtain information about how others deal with potential crisis producing problems.

### STRESS

The term stress means pressure and in human life it represents an uneasy experience. It is an unpleasant psychological and physiological state caused due to some internal and or external demands that go beyond our capacity.

### Body Coping Mechanism with Stress

Each person has his own normal (homeostatic) level of arousal at which he functions best. If something unusual in the environment occurs, this level of arousal is affected.

### General Adaptation Syndrome (GAS) Hans Selye, 1945

- Homeostatic mechanisms are aimed at counteracting the everyday stress of living. If they are successful, the internal environment maintains normal physiological limits of temperature, chemistry and pressure. If stress is extreme or long lasting, the normal mechanisms may not be sufficient. In this case, the stress triggers a wide-ranging set of bodily changes called General Adaptation Syndrome:
- When stress appears, it stimulates the hypothalamus to initiate the GAS through two pathways:
  - The first pathway is stimulation of the sympathetic division of the autonomic nervous system and adrenal medulla. This produces an immediate set of responses called the alarm reaction.
  - The second pathway, called the resistance reaction involves the anterior pituitary gland and adrenal cortex; the resistance reaction is slower to start, but its effects last longer.

#### Alarm Reaction

The alarm reaction or fight-or-flight response is the body's initial reaction to a stressor. It is a set of reactions initiated when the hypothalamus stimulates the sympathetic division of the autonomic nervous system, and the adrenal medulla.

The alarm reaction is meant to counteract a danger by mobilizing the body's resources for immediate physical activity.

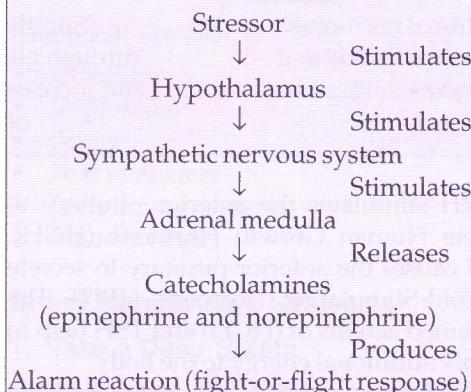
The stress responses which characterize the alarm reaction include the following:

- Heart rate and strength of cardiac muscle contraction increases; this circulates blood quickly to areas where it is needed to fight the stress.
- Blood vessels supplying skin and viscera, except heart and lungs, constrict; at the same time blood vessels supplying skeletal muscles and brain dilate; these responses route more blood to organs active in the stress responses,

thus decreasing blood supply to organs which do not assume an immediate active role.

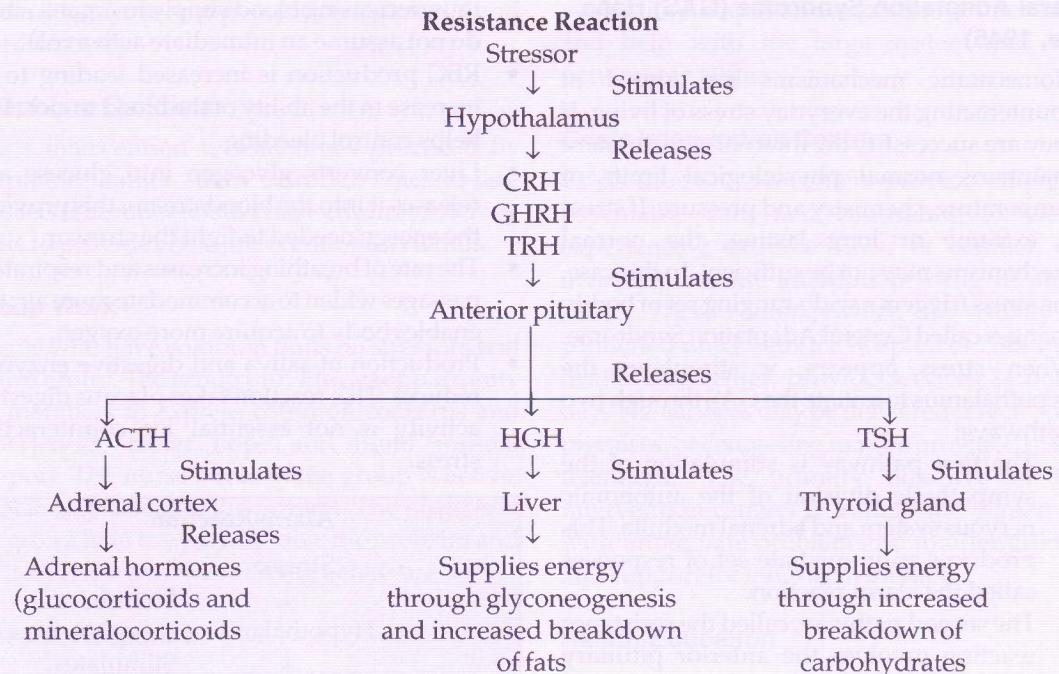
- RBC production is increased leading to an increase in the ability of the blood to clot. This helps control bleeding.
- Liver converts glycogen into glucose and releases it into the bloodstream; this provides the energy needed to fight the stressor.
- The rate of breathing increases and respiratory passages widen to accommodate more air; this enables body to acquire more oxygen.
- Production of saliva and digestive enzymes reduces. This reaction takes place as digestive activity is not essential for counteracting stress.

#### Alarm Reaction



#### Resistance Reaction

- The resistance reaction is the second stage in the stress response. It is initiated by regulating hormones secreted by the hypothalamus, and is a long-term reaction. These regulating hormones are Corticotrophin Releasing Hormone (CRH), Growth Hormone Releasing Hormone (GHRH) and Thyrotropin Releasing Hormone (TRH)
- CRH stimulates the anterior pituitary to increase its secretion of Adreno Corticotrophic Hormone (ACTH). ACTH stimulates the adrenal cortex to secrete more of its hormones. The action of these hormones helps to control bleeding, maintain blood pressure, etc.



- GHRH stimulates the anterior pituitary to secrete Human Growth Hormone (HGH). TRH causes the anterior pituitary to secrete Thyroid-Stimulating Hormone (TSH). The combined actions of (HGH) and TSH help to supply additional energy to the body.
- The resistance reaction allows the body to continue fighting a stressor for a long time. Thus it helps us to meet emotional crisis, perform strenuous tasks, fight infection, or resist the threat of bleeding to death.
- Generally, the resistance reaction is successful in helping us cope with a stressful situation, and our bodies then return to normal. Occasionally it fails to fight the stressor, especially if it is too severe or long-lasting. In this case, the General Adaptation Syndrome (GAS) moves into the stage of exhaustion.

### Exhaustion Stage

At this stage, the cells start to die, and the organs weaken. A long-term resistance reaction puts heavy demand on the body, particularly on the

heart, blood vessels and adrenal cortex, which may suddenly fail under the strain. In this respect, ability to handle stressors is to a large extent determined by the general health.

### Source of Stress

1. *Environmental stressors*  
Noise, pollution, traffic and crowding and weather.
2. *Physiological stressors*  
Illness, injuries, hormonal fluctuations, inadequate sleep or nutrition.
3. *Social stressors*  
Financial problems, work demands, social events, losing a loved one etc.
4. *Thoughts*  
Negative self talk, catastrophizing and perfectionism.
5. *Change of any kind can induce stress*
  - Fear of the new, the unknown
  - Feelings of personal insecurity
  - Feelings of vulnerability
  - Fear of rejection

- Need for approval
  - Fear of conflict
  - Fear of taking a risk
  - Fear of inability to cope with changed circumstances
6. *Individual personalities that can induce stress*
- Low self-esteem
  - Feelings of over-responsibility
  - Fear of loss of control
  - Fear of failure, error, mistakes
  - Chronic striving to be perfect
  - Chronic guilt
  - Chronic anger, hostility or depression
7. *Interpersonal issues that can induce stress*
- A lack of adequate support within the relationship
  - A lack of healthy communication within the relationship
  - A sense of competitiveness between the people involved
  - Threats of rejection or disapproval between people
  - Struggle for power and control in the relationship
  - Poor intimacy or sexuality within the relationship
  - Over dependency of one person on another
8. *System (family, job, school, club, organization issues that can induce stress)*
- Lack of leadership
  - Unco-operative atmosphere
  - Competitive atmosphere
  - Autocratic leadership
  - Lack of team work
  - Confused communication

### Symptoms of Stress

Symptoms of stress appear in many forms. Some symptoms only impact the person who is directly experiencing stress, while other symptoms may have an impact on our relationship with others.

#### *Physical Symptoms*

- Muscle tension
- Colds or other illnesses
- High blood pressure

- Rapid breathing or pounding of the heart
- Indigestion
- Ulcers
- Difficulty in sleeping
- Fatigue
- Headaches, back or neck problems
- Increased smoking or drinking alcohol
- Backaches
- Being more prone to accidents

#### *Cognitive Symptoms*

- Forgetfulness
- Unwanted or repetitive thoughts
- Difficulty in concentration
- Fear of failure
- Self criticism

#### *Emotional Symptoms*

- Irritability
- Depression
- Anger
- Fear or anxiety
- Feeling overwhelmed
- Mood swings

### Stress Management Strategies

#### 1. Take a Deep Breath

When you feel 'uptight' try taking a minute to slow down and breathe deeply. Breathe in through your nose and out through your mouth. Try to inhale enough so that your lower abdomen rises and falls. Count as you exhale – slowly.

#### 2. Practice Specific Relaxation Techniques

Relaxation techniques are extremely valuable tools in stress management. Most of the techniques like meditation, self hypnosis, and deep muscle relaxation work in a similar fashion. In this state both the body and the mind are at rest and the outside world is screened out for a time period. The practice of one of these techniques on a regular basis can provide a wonderfully calming and relaxing feeling that seems to have a lasting effect for many people.

### **3. Manage Time**

One of the greatest sources of stress is poor time management. Give priority to the most important ones and do those first. If a particularly unpleasant task faces you, tackle it early in the day and get over with it; the rest of your day will include much less anxiety.

Most importantly, do not overwork yourself, schedule time for both work and recreation.

### **4. Connect with Others**

A good way to combat sadness, boredom and loneliness is to see out activities involving others.

### **5. Talk it Out**

When you feel something, try to express it. Share your feelings. “Bottled Up” emotions increase frustration and stress. Talking with someone else can help clear your mind of confusion so that you can focus on problem solving. Also consider writing down thoughts and feelings. Putting problems on paper can assist you in clarifying the situation and allow you a new perspective.

### **6. Take a “Minute” Vacation**

Imagining a quiet country scene can take you out of the turmoil of a stressful situation. When you have the opportunity, take a moment to close your eyes and imagine a place where you feel relaxed and comfortable. Notice all the details of your chosen place, including pleasant sounds, smells and temperature or change your mental “channel” by reading a good book or playing relaxing music to create a sense of peace and tranquility.

### **7. Monitor Your Physical Comfort**

Wear comfortable clothing. If it’s too hot, go somewhere where it’s not. If your chair is uncomfortable, change it. If your computer screen causes eye-strain or backaches, change that, too. Don’t wait until your discomfort turns into a real problem. Taking five minutes to arrange back support can save you several days of back pain.

### **8. Get Physical**

When you feel nervous, angry or upset, release the pressure through exercise or physical activity. Running, walking or swimming are good options for some people, while others prefer dance or martial arts. Working in the garden, washing your car, or playing with children can relieve that “uptight” feeling, relax you and often will actually energize you. Remember, your body and mind work together. Most experts recommend doing 20 minutes of aerobic activity daily will reduce stress.

### **9. Take Care of Your Body**

Healthy eating and adequate sleep fuels your mind as well as your body. Avoid consuming too much caffeine and sugar. Take time to eat breakfast in the morning, it really will help keep going through the day. Well-nourished bodies are better prepared to cope with stress. If you are irritable and tense from lack of sleep or not eating right, you will be less able to “go the distance in dealing with stressful situations”. Increase the amount of fruits and vegetables in daily diet. Take time for personal interests and hobbies. Listen to one’s body.

### **10. Laugh**

Maintain your sense of humor, including the ability to laugh at yourself.

### **11. Know Your Limits**

There are many circumstances in life beyond your control, consider the fact that we live in an imperfect world. Know your limits. If a problem is beyond your control and cannot be changed at the moment, don’t fight the situation. Learn to accept what is, for now, until such time when you can change things.

### **12. Think Positively**

Refocus the negative to be positive. Make an effort to stop negative thoughts.

### **13. Clarify Your Values and Develop a Sense of Life Meaning**

Clarify your values and deciding what you really want out of your life, can help you feel better about yourself and have that sense of satisfaction and centeredness that helps you deal with the stresses of life. A sense of spirituality can help with this.

### **14. Compromise**

Consider co-operation or compromise rather than confrontation. A little give and take on both sides may reduce the strain and help you feel more comfortable.

### **15. Have a Good Cry**

A good cry during periods of stress can be a healthy way to bring relief to your anxiety, and it might prevent a headache or other physical consequences of "bottling" things up.

### **16. Avoid Self Medication**

Alcohol and other drugs do not remove the conditions that cause stress. Although they may seem to offer temporary relief, these substances only mask or disguise problems. In the long run, alcohol use increases rather than decreases stress, by changing the way you think and solve problems and by impairing your judgment and other cognitive capacities. Medications should be taken only on the advice of a doctor.

### **17. Look for the "Pieces of Gold" Around You**

Pieces of gold are positive or enjoyable moments or interactions. These may seem like small events but as these "pieces of gold" accumulate they can often provide a big lift to energy and spirits and help you begin to see things in new, more balanced way.

## **Role of a Nurse in Stress Management**

### **Assessment**

#### *Assessment of the Person*

Assess for the following characteristics in the individual. Such individuals are at high risk of developing stress – related disorders:

- Rigid and self-punishing moral standards
- High and unrealistic expectations
- Too much dependence on others for love and affection and approval
- Inability to master change or learn new ways of dealing with frustration
- Easily prone to extreme emotional responses of fear, anxiety and depression
- Type A personality persons

In addition, the presence of stressful life events such as births, deaths, marriages, divorces, retirement, economic success or failure etc can predispose the person to stress-related illnesses.

#### *Assessment of the Family*

Assess the family's perception of the problem, and whether it is supportive of the client's efforts at coping.

#### *Assessment of the Environment*

Occupations with a high degree of stress; adverse environmental influences like too much of lighting, temperature etc.

### **Interventions**

Interventions are directed towards relief of acute or chronic stress. A nurse can help the person to examine the situation, identify possible solutions and accept his feelings without guilt or fear.

People suffering from acute stress-related illnesses often need to change their lifestyles and ways of relating to others. The initial work of the nurse involves helping the client to recognize that change is essential, and develop clear personal objective in relation to the change.

Some clients may show resistance to a necessary change. In such cases, nursing measures include:

- Increasing the client's awareness as an actual or potential health problem exists.
- Helping him realize that the health problem can increase if personal changes do not occur.
- Identifying all possible resources (his family, friends etc.). To support the client through the process of change, and co-operation with the treatment.

- When the client becomes aware of the nature of the health problem and is told of the change needed, he often experiences a feeling of anxiety, depression and anger. The client is encouraged to talk about the losses that have resulted from the behavior change. Recognizing this grieving process provides the nurse with clear direction as to how she can help the client.
- Family members also need accurate information about the nature of the disorder, and how they can help the client in coping with stress. The client and families also need to be informed about various alternatives such as meditation, yoga, relaxation training etc. These techniques have a valuable role to play in helping individuals cope with stressful life events.
- In all this, the nurse must always bear in mind that they are only facilitators of the change process, and the clients have the rights and responsibilities in relation to change.

### **REVIEW QUESTIONS**

- Stages of grief (Feb 2001)
- Definition and types of crisis (Apr 2006)
- Phases of crisis
- Crisis intervention (Feb 2000, Nov 2002, Nov 2003, Oct 2004)
- Role of a nurse in crisis intervention (Nov 2001)
- Bereavement (Oct 2005)
- What is normal grief reaction (Apr 2004)
- Grief process (Nov 2003)
- Maturational Crisis (Nov 2003)

# 16

## *Legal Aspects of Mental Health Nursing*

- THE INDIAN LUNACY ACT (1912)
- THE INDIAN MENTAL HEALTH ACT (1987)
- LEGAL ISSUES IN PSYCHIATRY
- LEGAL ASPECTS IN PSYCHIATRIC NURSING
  - Role of the Nurse in Admission Procedure
  - Role of the Nurse in Parole
  - Role of the Nurse in Discharge Procedure
  - Basic Rights of Psychiatric Patients and Nurse's Responsibilities
  - Nursing Malpractice
  - Informed Consent
  - Substituted Consent
  - Confidentiality
  - Record Keeping
- LEGAL RESPONSIBILITIES OF A MENTALLY ILL PERSON

A psychiatric nurse is in the ward 24 hours of the day, and the final responsibility of the ward management is on the nurse. She should therefore be well-versed in legal aspects of care and treatment of the mentally ill. This knowledge helps her to guide the patients and relatives in matters related to rights of the patient and other aspects of mental health care.

There are two Acts concerned with the care and treatment of the mentally ill:

- The Indian Lunacy Act of 1912
- The Indian Mental Health Act of 1987.

### **THE INDIAN LUNACY ACT (1912)**

It is derived from English Lunacy Act, 1890 and it contains eight Chapters.

### **CHAPTER I**

It contains some preliminary information and definitions.

### **CHAPTER II**

It contains mainly the procedure to be followed to admit a psychiatric patient into a mental hospital.

### **CHAPTER III**

It describes the procedure to be followed for administering care, treatment and discharge.

In Chapter III the term 'Parole' refers to the 'permission given to patients to perform certain rituals or attend certain family functions.' During parole, the patient can leave the hospital any time and can be brought back forcefully if he does not return within a maximum period of 90 days.

The remaining Chapters (IV to VIII) deal with establishment of asylums, expenses of lunatics and the rules to be imposed by the state government regarding care of lunatics.

### **THE INDIAN MENTAL HEALTH ACT (1987)**

The Indian Mental Health Act is derived from Mental Health Act of England and Wales (1959 amended in 1982). The Mental Health Bill became the Act 14 of 1987 on 22nd May 1987.

### **Reasons for Enactment**

1. The attitude of the society towards the mentally ill has changed considerably and it is now realized that no stigma should be attached to such illness, as it is curable practically when diagnosed at an early stage. Thus the mentally ill individuals should be treated like any other sick persons and the environment around them made as normal as possible.

2. The experience of working of the Indian Lunacy Act, 1912 has revealed that it has become outmoded with the rapid advancement of medical science and the understanding of nature of malady. It has therefore become necessary to make fresh legislation in accordance with the new approach.

### Objectives of the Indian Mental Health Act

- To regulate admission into psychiatric hospitals and psychiatric nursing homes.
- To protect society from the presence of mentally ill persons.
- To protect citizens from being detained in psychiatric hospitals/nursing homes without sufficient cause.
- To regulate maintenance charges of psychiatric hospitals/nursing homes.
- To provide facilities for establishing guardianship of mentally ill persons who are incapable of managing their own affairs.
- To establish central and state authorities for mental health services.
- To regulate the powers of the government for establishing, licensing and controlling psychiatric hospitals/nursing homes.
- To provide legal aid to mentally ill persons at state expense in certain cases.

The Act contains 10 Chapters.

### CHAPTER I

It contains preliminary information. Some definitions included in this are:

- *Psychiatric hospital/nursing home:* A hospital/nursing home established or maintained by the government or any other person for the care of mentally ill persons.
- *Mentally ill person:* A person who is in need of treatment by reason of any mental disorder other than mental retardation.
- *Psychiatrist:* A medical practitioner possessing a post-graduate degree or diploma in psychiatry recognized by the MCI (Medical Council of India).

- *Reception order:* An order made under the provisions of this Act for the admission and detention of a mentally ill person in a psychiatric hospital/nursing home.

### CHAPTER II

It deals with establishment of central and state authorities for regulation and coordination of mental health services.

### CHAPTER III

It provides guidelines for establishment and maintenance of psychiatric hospitals/nursing homes.

### CHAPTER IV

It deals with the procedures for admission and detention in psychiatric hospitals/nursing homes.

#### 1. Admission on Voluntary Basis

Any person who considers himself to be mentally ill and wishes to be admitted to a psychiatric hospital may apply to the medical officer-in-charge; if he is a minor, the guardian can make this application on his behalf.

The medical officer should make inquiry within 24 hours and should admit the patient if he opines that treatment is required. The voluntary patient thus admitted is now bound to abide by the rules made by the institution.

#### 2. Admission under Special Circumstances

Any mentally ill patient who is unwilling for admission on a voluntary basis may be admitted and kept as an inpatient in a psychiatric hospital/nursing home. For such purpose an application should be made out on his/her behalf by a relative or a friend of the mentally ill person, provided the medical officer deems fit.

#### 3. Admission under Reception Order

*On application:* Only a relative not other than husband, wife, guardian or a friend can make out

an application for the admission of a mentally ill patient. Such an application should be made out to the magistrate in writing supported by two medical certificates, one of them issued by a gazetted medical officer. However no person being a minor or one who has not seen the mentally ill patient in the last 14 days can make such an application. The patient may now be admitted after the magistrate obtains consent from the medical officer in-charge of the mental hospital.

The medical officer in-charge can extend inpatient treatment to more than 6 months by making such an application to the magistrate.

*On production before the magistrate:* Mentally ill patients exhibiting violent behavior, creating obscene scenes and dangerous to the society can be detained by the police officer and produced in court within 24 hours of such detention, supported by two medical certificates, subsequent to which the magistrate issues a reception order.

### 4. Admission in Emergencies

The medical officer in-charge may order the admission of a mentally ill patient if he thinks he is dangerous to himself or others. However the patient should be produced before the magistrate within 24 hours (maximum time limit is 72 hours, which is exclusive of the examination period), or the magistrate himself may visit the psychiatric hospital/nursing home and pass reception order on examination.

### 5. Temporary Treatment Order

It is an order issued by the magistrate in cases where the risk is perceived to the patient's life or to that of others. If the medical officer in-charge feels it necessary to bring legal authorities into the picture he can do so by applying to the magistrate. Alternatively the relatives can get the magistrate to issue an order for treatment. In such case a single medical certificate is required which is valid for 6 months.

### 6. Admission of Mentally Ill Prisoners

A mentally ill prisoner may be admitted into a mental hospital on the order of the presiding officer or a court.

### 7. Miscellaneous Admission

A mentally ill patient can be admitted either on humanitarian grounds (e.g. wanderers) or for observation purpose. Social workers can obtain an order from the magistrate pending report from medical officer.

## CHAPTER V

It deals mainly with the procedure to be followed for the **discharge** of mentally ill persons from a mental hospital under different circumstances.

### 1. Discharge of a Patient Admitted on Voluntary Basis

Medical officer in-charge of psychiatric hospital/nursing home on recommendation from two medical practitioners preferably a psychiatrist, can issue directions for discharge of the patient.

### 2. Discharge of a Patient Admitted under Special Circumstances

A relative or a friend may make an application to the medical officer for care and custody of the patient. The relatives are required to furnish a bond with or without sureties, along with an undertaking that the mentally ill person shall be prevented from causing injury to self or others.

### 3. Discharge of a Patient Admitted on Reception Order

An applicant who feels that the patient has recovered from illness may make an application for discharge to the magistrate. A certificate should accompany such an application from medical officer in-charge of the psychiatric hospital/nursing home. If the magistrate deems fit he may issue an order for discharge.

### 4. Discharge of a Patient Admitted by Police

In cases where the police detain the mentally ill individual in hospital, he may be discharged after the family members agree in writing to take proper care, and the medical officer-in-charge opines that he is fit to be discharged.

### 5. Discharge of a Mentally Ill Prisoner

The hospital authorities have to report every 6 months about the person's state of mind to the authority, which had ordered detention. As soon as they find that the person is fit to stand the trial, they have to inform about the same to the authority concerned. The person is then handed over to the prison officer for further legal action.

### Leave of Absence

On application by a relative or others to the medical officer-in-charge and a bond duly signed stating that the patient will be taken proper care of and prevented from injuring self or others, leave of absence may be granted (for a period of maximum 60 days).

## CHAPTER VI

It deals with judicial enquiry regarding mentally ill persons possessing property, their custody and management of property. A guardian may be appointed by court of law on behalf of an alleged mentally ill person incapable of looking after self and property.

## CHAPTER VII

It deals with ways and means to meet the cost of maintenance of mentally ill persons detained in psychiatric hospital/nursing home.

## CHAPTER VIII

It is the latest addition to the Act, which provides for the protection of human rights of mentally ill person. These rights include:

1. No mentally ill person shall be subjected during treatment to any indignity (physical or mental) or cruelty.

2. No mentally ill person under treatment shall be used for the purpose of research unless

- such research is of direct benefit to him.
- a consent has been obtained in writing from the person (in voluntary admission) or from the guardian/relative (if admission was involuntary).

3. No letter or communication sent by or to a mentally ill person shall be intercepted, detained or destroyed.

## CHAPTER IX

It deals with procedures to be followed for the establishment and maintenance of psychiatric hospitals/nursing homes, and the penalties, which can be relatively severe and explicit, for contravening them.

## CHAPTER X

It deals with clarification pertaining to certain procedures to be followed by the medical officer-in-charge of the psychiatric hospital/nursing home.

## LEGAL ISSUES IN PSYCHIATRY

### 1. Laws Relating to Psychiatry in India

1. The Care and Treatment Legislation (Mental Health Legislations)
2. Criminal Responsibilities Formulation (Criminal Laws)
3. Civil Status Provisions (Civil Laws)

### 2. Mental Health Related Legislations

- Mental Health Act 1987
- Persons with Disabilities Act 1996
- Rehabilitation Council of India Act 1992
- Juvenile Justice Act 1986
- Consumer Protection Act 1986

### 3. Civil Laws Relating to Mental Ill Persons

- Indian Evidence Act 1925 Sec. 118
- Law of Contract Sec. 6, 11 and 12
- Right to Vote and Stand for Election- Act 326, 102 of the Constitution of India

- Law of Torts
- Testamentary Capacity- Indian Succession Act 1925 Sec. 59
- Marriage and Mental Health Legislation
  - Indian Divorce Act 1869
  - Parsi Marriage + Divorce Act 1936
  - Dissolution of Muslim Marriage Act 1939
  - The Special Marriage Act 1954
  - The Hindu Marriage Act 1955, 1976
  - The Family Court Act 1984

### **4. Civil Laws Relating to Psychiatry**

- Provisions as to Accused Persons of Unsound Mind Secs. 328-339 Cr. P.C. 1973
- Criminal Responsibility Sec. 84 IPC-1860
- Attempt to Commit Suicide Sec. 309 IPC
- Right to Private Defence Against an Insane Person Sec. 98 IPC
- Unnatural Offences Sec. 377 IPC (Sexual Perversions)
- Affrays (Sec. 159 In Mania)
- Misconduct in Public under Intoxication (e.g. Alcohol Defence Sec. 510 IPC)
- NDPS Act 1985 (Amended 1988)

### **5. Suicide and Indian Law**

- Suicide is the only criminal act for which a person is punished if he fails in the attempt to do so
- "No person shall be deprived of his life" Act 21 constitution of India
- Sec. 309/IPC- attempt to commit suicide-punishable
- 1994 – S.C. Judgment – Sec. 309 was declared void
- Sec. 306 – abetment of suicide an offence
- No specific laws for assisted suicide and euthanasia

### **6. The Narcotic Drug and Psychotropic Substances Act (Act 61 of 1985)**

In India the opium Act of 1857 was revised first in 1878. In 1950, the opium Act of 1878 was revised as the Opium and Revenue Laws Act 1950.

On 16<sup>th</sup> September 1985, the above mentioned Acts were repealed and NDPSA Act 61 of 1985 was enforced.

### **Contents**

- The act includes Narcotic drugs (opium, poppy, straw, cannabis, cocaine, coca and all related synthesized drugs) and psychotropic substances (76 drugs and their derivatives e.g. major tranquilizers, minor tranquilizers, pentazocine, barbiturates etc.).
- In this act if a person produces, possesses, transports, imports, sells, purchases or uses any narcotic drugs or psychotropic substances (except 'Ganja') he shall be punishable with
  - Rigorous imprisonment for not less than 10 years, which may be extended up to 20 years and a fine of not less than 1 lakh rupees, which may extend to two lakh rupees.
  - For repeat offence a rigorous imprisonment of not less than 15 years which may be extended upto 30 years and a fine of not less than 1.5 lakh rupees, which may be extended up to 3 lakh rupees.
  - For handling 'Ganja', a rigorous imprisonment which may extend to 10 years and a fine upto 1 lakh rupees.
- On carrying 'small quantities' e.g. Heroin – 250 mg, Opium – 5 gm, Cocaine – 125 mg, Charas – 5 gm, as were later specified in this act, the punishment may extend to 1 year or a fine or both. For Ganja, (below 500gms), imprisonment is up to 6 months.
- Under a specified court order, there is a provision for detoxification of the patient.
- Under a later enactment, the prevention of illicit traffic in Narcotic Drugs and Psychotropic Substances Act (NDPSA) 1988 (Act 46) has been passed. Now there is a provision for preventive detention, seizure of property, death penalty if a person is bound to be trafficking more than or equal to 1 kg of pure heroin despite conviction and warning on the first attempt.

## LEGAL ASPECTS IN PSYCHIATRIC NURSING

In no other type of nursing are the legal and ethical considerations of practice so crucial as in psychiatric nursing. Thus, knowledge of the law regarding psychiatry in the area where the nurse is practicing helps her to protect herself from liability and the patient from unnecessary detention and mistreatment.

### Role of the Nurse in Admission Procedure

- A most important feature of the admission procedure involves settling the patient in the ward. It begins with introducing him to the other staff members and patients.
- Before assigning him a bed consider his biological and emotional needs. If he seems to be nurturing suicidal ideation or is floridly psychotic, he should be located in a place where he can be closely observed.
- He should be shown various facilities like eating, recreation, bathroom facilities, etc.
- Acquaint him with some of the ward rules, e.g. meal time, ward activities, visiting hours, how to make appointments to see staff members, timings of any group meetings, etc.
- The patient and his relatives are likely to have all sorts of anxieties about various procedures and investigations. The nurse needs to be sensitive to these feelings, and give enough time and attention and allow them to express their feelings about the patient's condition, treatment and outcome. All information should be provided as appropriate.

### Role of the Nurse in Parole

Parole is the permission given to patients to perform certain rituals or attend certain family functions.

- Relatives are clearly instructed about the purpose for which the patient is being sent home and when he should be brought back.
- Instruct the relatives as to how they should converse or behave with the mentally ill person according to the instructions given by the doctor.

- If the patient is receiving any medications, insist on regularity and give necessary instructions to the family members about dosage, side-effects, etc.

### Role of the Nurse in Discharge Procedure

- Nurse must ensure that the patient leaves the unit with all belongings and personal effects, has the appropriate medications with him, and appointment for follow-up has been made and understood.
- All necessary instructions especially regarding his medication regimen, side-effects etc. must be clearly given to the patient and his family members.
- Any paper work, signing of documents should be completed. The hospital file along with all charts and notes should be sent to the medical records section.
- The nurse should ascertain his travel plan and offer assistance if necessary.
- The nurse must bear in mind that the patient may have mixed feelings about leaving the hospital and going back to his home environment. She should help him cope with any distress about separating from his new-found friends and staff members.

### Basic Rights of Psychiatric Patients and Nurse's Responsibilities

Psychiatric patients are often the least capable of protecting their own rights. It is therefore one of the responsibilities of the nurse to guide the patients and relatives in matters related to their rights and protect the patient from any mistreatment.

#### *Some of the Rights of Psychiatric Patients*

- The right to wear their own clothes.
- The right to have individual storage space for their private use.
- The right to keep and use their own personal possessions.
- The right to spend a sum of their money for their own expenses.

- The right to have reasonable access to all communication media like telephone, letter writing and mailing.
- The right to see visitors every day.
- The right to treatment in the least restricted setting.
- The right to hold civil service status.
- The right to refuse electroconvulsive therapy.
- The right to manage and dispose of property and execute wills.

*Nurse's implications for protecting patient's rights*

- To protect patient's rights, the nurse should be aware of these rights in the first place.
- She should ensure that ward procedures and policies should not violate patient's rights.
- Discussing these rights with the mental health team and including these rights in the nursing care plan is all part of her responsibility in protecting the patient's rights.

### **Nursing Malpractice**

When a prudent nurse expected to meet the normal standards of care, causes a breach by deviating from the norms, it is termed as nursing malpractice. Such breach of act can invoke legal proceedings against the nurse for not discharging her duty diligently and in good faith.

If the malpractice suit has to stand and be decreed in favor of the aggrieved patient, he will have to prove various facets which contributed to the breach. However it is to be noted that the burden of proof lies with the patient who in this case is the plaintiff. The various facets include:

- the nurse had a duty to discharge due standards of care to the patient
- the nurse's performance was well below the expected standards, thus causing a breach
- substandard care provided should be construed to have adversely affected the patient and family
- the actual proof of adverse effects/injury caused.

### **Informed Consent**

In the course of normal treatment a series of interactions result between a patient and a

physician. During such interactions the patient is allowed to fully consider and comprehend the information about the proposed treatment. Such consent is termed as informed consent. It includes the mode of administering the treatment, prognosis, side-effects and the risks.

However, in the case of psychiatric patients the ability to give informed consent as regards a procedure is highly debatable due to the nature of the problem. Though most of the patients perceive and act in their own best interests, some may not be capable of giving a valid consent. Due to such variations, the patients have to be screened for the following:

- whether the patient is competent to give informed consent
- whether information provided to the patient is assimilated on a regular basis and understood
- whether enough opportunity and freedom are vested with the patient to reject/revoke the consent during a specific course of treatment.

### **Substituted Consent**

When it is deemed that a patient is incapable of giving informed consent, health service providers should obtain substituted consent for the procedure/treatment. It refers to an authorization given by another individual, being a guardian appointed by the court or the kith and kin on behalf of the patient.

### **Confidentiality**

During the nurse-patient relationship a lot of information is gathered through direct and indirect sources, which is both verbal and written. Keeping in view the ethics of the nursing practice, such information gathered is kept confidential and best used for providing enhanced care rather than for other purposes such as gossip or personal gain.

Any breach of confidentiality could jeopardize the best interests of the patient, be it social or economical, keeping in view the social stigma attached to mental illness.

### **Record Keeping**

Nursing notes and progress records constitute legal documents and hence should be maintained carefully. They should be non-judgemental and the statements made should be objective in nature.

### **LEGAL RESPONSIBILITIES OF A MENTALLY ILL PERSON**

In legal parlance responsibility refers to liability/accountability for his/her acts of negligence. If such acts are contrary to the law of the land, suitable punishment is awarded. A person of unsound mind committing an act contrary to law, incapable of knowing its nature shall not be held for the offence.

However a point to be noted is that 'irresistible impulse test' is used in unison with the M'Naghten rule. It refers to a situation where a person may know the difference between right and wrong but finds himself impulsively driven to commit the crime.

M'Naghten rule states that the individual at the time of the crime did not know the nature and quality of the act and if he did know what he was doing, he did not comprehend it to be wrong. These rules are also referred to as the 'nature and quality rule' and 'right from wrong' test.

'Durham test' or 'product rule' states that an accused person is not criminally responsible if his/her unlawful act is the product of mental disease or mental defect.

As per the American Law Institute's (ALI) test, a person lacking adequate capacity to realize the criminality of his act or conformity of his conduct to the provisions of law is not responsible for performing such an act.

### **Civil Responsibilities of a Mentally Ill Person**

#### *Management of Property*

The court may on an application from any relative direct an inquiry to ascertain whether a person is of unsound mind and incapable of

managing his property. In such a case a manager is appointed by the court of law to take care of his property, which may include sale or disposal of the property to settle his debts/expenses.

#### *Marriage*

As per the Hindu Marriage Act (1955), marriage between any two individuals one of whom was of unsound mind at the time of marriage is considered null and void in the eyes of the law. Unsoundness of mind for a continuous period can be sighted as a ground for obtaining divorce. The other party can file for divorce when lunacy continues for a period of more than 2 years after marriage. However if divorce is filed after a 3-year period, divorce is granted with a precondition that the other party has to pay maintenance charges for the mentally ill person.

#### *Testamentary Capacity*

As per the Indian Succession Act, testamentary capacity of the mental ability of a person is a precondition for making a valid will. The testator must be a major, free from coercion, understanding and displaying soundness of mind. At times doctors and nurses are called upon to witness the will of an ailing person. Under such circumstances the doctor tests the testator for orientation, concentration and memory. A person affected by delusional disorder can also make a valid will if those delusions are not related to the disposal of the property.

#### *Right to Vote*

A person of unsound mind cannot contest for elections or exercise the privilege of voting.

In conclusion, nursing practice must confirm to pre-set legal standards and continuously re-orient itself to the ever evolving legal standards. It is only the motivated and capable nurse who can incorporate legal knowledge while dispensing patient care, and it is to her that many patients will turn for information and care.

**REVIEW QUESTIONS**

- Indian Mental Health Act (Nov 2003, Oct 2004, Apr 2006)
- Indian Lunacy Act (Nov 2002, Apr 2006)
- Parole or leave of absence (Oct 2005)
- Types of admission in mental hospital (Feb 2000)
- Admission procedures for a mentally ill patient (Apr 2003, Nov 2003, Apr 2006)
- Discharge procedure for a mentally ill patient (Oct 2005)
- Legal aspects in psychiatric nursing (Nov 2000)
- Protection of the rights of the mentally ill (Nov 2003)
- Rights of mentally ill patient (Nov 2002)

# 17

## *Community Mental Health Nursing*

- COMMUNITY MENTAL HEALTH IN INDIA
- COMMUNITY MENTAL HEALTH CENTERS—CERTAIN FEATURES
- COMMUNITY FACILITIES FOR PSYCHIATRIC PATIENTS
  - Psychiatric Hospitals
  - Partial Hospitalization
  - Quarterway Homes
  - Halfway Homes
  - Self-help Groups
  - Suicide Prevention Centers
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  - Objectives
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The methods of treating mental illness have changed dramatically in the past century. Community mental health as a treatment philosophy, was mandated by the Community Mental Health Centers Act of 1963, thus bringing about the shift of mental health care from the

institution to the community, and heralding the era of deinstitutionalization.

### **COMMUNITY MENTAL HEALTH IN INDIA**

The overall goal of community mental health as outlined by Mrs. Indira Gandhi in May 1981 while addressing the World Health Assembly is as follows:

“In India, we would like to go to homes instead of large numbers gravitating towards centralized hospitals. Services must begin where people are and where problems arise.”

Active thinking in this area marked the decade of 1970s, and concern for organizing mental health services was expressed in national and regional forums. Notable among these are the Indian Psychiatric Society's seminars/workshops at Madurai (1971), Trivandrum (1975) and Nagpur (1976).

One of the most important elements in the supply of health care in India has been the Primary Health Center (Provision of mental health care is one of the components of Primary Health Care). This provides a unique opportunity to provide mental health care through the multidisciplinary approach and collaborative services. Failure in this regard is due to complex problems such as limited resources, lack of trained manpower and inadequate long-term planning.

The next important phase of development of mental health services was the setting up of General Hospital Psychiatric Units (GHPUs). The GHPU provided a big push for the greater acceptance of psychiatric services by the public without fear of social stigma.

The next phase of development of mental health services was the community care approach. Two centers that took up community mental health work in 1975 were Bangalore and Chandigarh. Thus the approach to development of services has been a rapid transition from mental hospitals to GHPUs and to community care.

According to mental health experts, a community mental health program should:

- provide mental health care in the community as opposed to institutional care
- focus services on a total community or population rather than on an individual patient
- focus on preventive and promotive services as distinguished from therapeutic ones
- provide continuity and comprehensiveness of services rather than fragmentary and symptom-based care
- provide indirect services such as consultation and mental health education rather than direct services alone
- include selection and training of primary care workers from the local community in order to provide basic mental health care

### **COMMUNITY MENTAL HEALTH CENTERS—CERTAIN FEATURES**

#### *Commitment*

Commitment suggests that the centers should identify all the mental health needs of the population. This requires that the mental health services be located close to people's residences or workplaces to make it easy for them to identify illness and obtain treatment.

#### *Services*

Integrated and balanced services in response to expressed local needs must be provided.

#### *Long-term Care*

Continuity of care enables a single clinician to follow a patient through emergency services, hospitalization and partial hospitalization as a

transition to the community and out-patient treatment and follow-up.

#### *Case Management*

Case managers are clinicians who can provide continuity of care; they ensure continuing treatment by initiating contact during hospitalization and continuing support through after-care.

#### *Community Participation*

Community should participate in decisions about their mental health care needs and programs.

#### *Evaluation and Research*

Evaluation is the process of obtaining information about a community mental health program and its effect on people and situations.

Research may focus specifically on key issues and address a particular disorder or a treatment method.

### **Possible Community Mental Health Practice Sites**

- Community mental health centers
- Youth centers
- Private practice office
- Crisis centers
- Shelters
- Clients' homes
- School and day care centers
- Nursing homes
- Day hospital facilities
- Emergency department of community hospitals
- Churches, temples, mosques

### **COMMUNITY FACILITIES FOR PSYCHIATRIC PATIENTS**

In the community, seven provisions are required to replace long-term care in hospital:

- Suitable well-supported carers
- Suitable accommodation
- Suitable occupation
- Arrangements to ensure the patient's collaboration with treatment

- Regular reassessment, including assessment of physical health
- Effective collaboration amongst carers
- Continuity of care and rapid response to crises

Some facilities available include:

- A. Psychiatric hospitals:** Hospitals have become part of a continuum of mental health services available to patients and their families, and offer a variety of treatments for psychiatric disorders.
- B. Partial hospitalization:** Partial hospitalization is an innovative alternative to hospitalization. It is ideally suited to most of the psychiatric syndromes, particularly chronic psychotic disorders, neurotic conditions, personality disorders, drug and alcohol dependence and mental retardation. Day care centers, day hospitals and day treatment programs come under partial hospitalization.

Partial hospitalisation has the advantages of lesser separation from families, more involvement in the treatment program and a lessening of patient's preoccupation with the illness, which may be intensified by full hospitalization.

#### Main day care centres in India

- Sanjivini, New Delhi
- SCARF (Schizophrenia Research Foundation), Chennai, has started a day care center called "BAVISHYA" in 1985
- Association of the Friends of Mentally Ill, Mumbai
- Institute of Mental Health, Ahmedabad
- Psychiatric Center, Kolkata
- NIMHANS, Bangalore
- Krupamayie Institute of Mental Health, Miraj
- Anugraha Day Care Center, Chennai
- The Richmond Fellowship Society, Bangalore

- C. Quarterway homes:** This is a place usually located within the hospital campus itself, but not having the regular services of a hospital. There may not be routine nursing staff or routine rounds, and most of the activities of the place are taken care of by the patients themselves.

Examples of such homes are 13th and 14th psychiatric wards of NIMHANS at Bangalore.

**D. Halfway home:** A halfway home is a transitory residential center for mentally ill patients who no longer need the full services of a hospital, but are not yet ready for a completely independent living. It attempts to maintain a climate of health rather than of illness, and to develop and strengthen individual capacities. At the same time it enables the recognition of problems that require medical attention, and permits the discovery of conditions in the community which are acting adversely on the individual. Thus, halfway homes have a major role in the rehabilitation of the mentally ill individual.

#### Objectives

- To ensure a smooth transition from the hospital to the family.
- To integrate the individual into the mainstream of life.

#### Activities

Community mental health nurses play a vital role in monitoring the progress of discharged patients in halfway homes, especially with regard to their medication regimen and coordination of care. Some of the interventions carried out in halfway homes include:

- Assessment: *Clinical* assessment including assessing for residual psychiatric symptoms which may affect his ability to function; *social* assessment including assessing family support, attitude of family members and economic status of the family; *psychological* assessment including assessing self-esteem, confidence, patient's level of motivation; *vocational* assessment including assessing physical strength, hand coordination, attention, concentration etc.
- Reduction of impairments: This includes reduction or elimination of the symptoms and cognitive impairments that interfere with social and vocational performance. These impairments are eliminated for the greater part by various psychotropic agents.

- Remediation of disabilities through skill training: Skill training is used to remediate disabilities in social, family and vocational functioning. Patients generally require training in self-care skills, interpersonal skills, vocational and employment pursuits, recreational and leisure skills.
- Remediating disabilities through supportive interventions: These strategies aim at helping the individuals compensate for handicaps by learning skills in living and working environments, adjusting the individual and family expectations to a level of functioning that is realistically attainable.

#### *Outcomes*

Expected outcomes could be: Successful return of the patients to their homes, prevention of relapses, economic self-sufficiency made possible through vocational counseling and self-employment programs.

Nurses need to be familiar with the various halfway homes available in the community; collaboration with such facilities is absolutely essential for successful rehabilitation. Some of the halfway homes available in India include:

- Medico-Pastoral Association, Bangalore
- Atmashakti Vidyalaya, Bangalore
- Richmond Fellowship, Bangalore
- Puraskara Aftercare Home, Bangalore
- Cadabam's Home for the Mentally Disabled, Bangalore
- Family Fellowship Society for Psychosocial Rehabilitation, Bangalore
- Raju Rehabilitation Foundation, Bangalore
- YWCA Halfway Home for Mentally Ill, Chennai
- Dr. Boaz's Rehabilitation Center, Chennai
- Dr. Dhairyam's Psychotherapy and Rehabilitation Center, Chennai
- Sowkya Halfway Home at Madurai
- Delhi Psychosocial Rehabilitation Society
- Paripurnata Halfway Home, West Bengal
- Society for Mental Health, Kerala

#### **E. Self-help groups**

- Self-help groups are composed of people who are trying to cope with a specific problem or

life crisis, and have improved the emotional health and well being of many people. Usually organized with a particular task in mind, such groups do not attempt to explore individual psychodynamics in great depth or to change personality functioning significantly.

- A distinguishing characteristic of self-help groups is their homogeneity. The members have the same disorders and share their experiences good or bad, successful or unsuccessful, with one another. The members work together using their strengths to gain control over their lives. By so doing, they educate each other, provide mutual support, and alleviate the sense of alienation usually felt by people drawn to this kind of group. In other words, self-help groups are based on the premise that *people who have experienced a particular problem are able to help others who have the same problem*.
- One of their most important functions is to demonstrate to individuals that they are not alone in having a particular problem. Sharing each others' experiences not only helps the members by providing mutual support, but also by generating alternate ways to view and resolve problems. Thus they help in overcoming maladaptive patterns of behavior or states of feeling that traditional mental health professionals have not generally dealt with successfully.
- Self-help groups emphasize cohesion, which is exceptionally strong in these groups. Because the group members have similar problems and symptoms, they develop a strong emotional bond. But each group may have its unique characteristics, to which the members can attribute magical qualities of healing.
- Strategies: The strategies used by group leaders include promotion of dialogue, self-disclosure and encouragement among members. Concepts used in support groups include psychoeducation, self-disclosure, and mutual support.

- Processes: The processes involved in self-help groups are social affiliation; learning self-control; and modeling methods to cope with stress and acting to change the social environment.
- The end result is that these groups prevent physical, emotional and social problems and breakdowns; improve an individual's or a family's quality of life; and provide the education necessary to develop the member's potential further. Examples of self-help groups are Alcoholics Anonymous (AA), Association for Mentally Disabled (AMEND).
- The self-help group movement in India is in its ascendancy. One of the recent developments is the start of AMEND in Bangalore. People with mental illness suffer from social stigma and discrimination. More so their family members are struck with disbelief, loneliness and sorrow. Families of such people have got together to form an organization in Bangalore called AMEND - Association for Mentally Disabled, under the leadership of Dr. Nirmala Srinivasan. AMEND has been advocating and practicing family based care. At AMEND, families share experiences, talk about side effects of medication and discuss how they can communicate problems to psychiatrists. AMEND also conducts workshops to train consumers in living skills so that they can look after themselves, tell them what is wrong with one self, why they need to take their medication, and what can happen if they stop and so on. Many of AMEND's consumers have been rehabilitated and are holding jobs as part of their occupational therapy.
- F. **Suicide prevention centres:** There are many suicide prevention centers in India in the voluntary sectors doing good work and helping those in need. Some of them are:
  - Helping Hands and MPA in Bangalore
  - Sneha in Chennai
  - Sahara in Mumbai
  - Sanjivini and Sumaitri in New Delhi

#### G. Other

- Community group homes
- Large homes for long-term care
- Hostels
- Home care programs
- District rehabilitation centers

### **COMMUNITY MENTAL HEALTH—PSYCHIATRIC NURSING**

Community mental health-psychiatric nursing is the application of specialized knowledge to populations and communities to promote and maintain mental health, and to rehabilitate populations at risk that continue to have residual effects of mental illness.

Psychiatric nursing in the community setting differs markedly from its hospital counterpart. The community setting requires that the psychiatric nurse possess knowledge about a broad array of community resources and be flexible in approaching problems related to individual psychiatric symptoms, family and support systems and basic living needs such as housing and financial support.

### **Community Mental Health-Psychiatric Nurse Attributes**

- Awareness of self, personal and cultural values
- Non-judgmental attitude
- Flexibility
- Problem solving skills
- Ability to cross service systems (e.g. to work with schools, other health care providers, employers, etc.)
- Knowledge of community resources
- Willingness to work with the family or significant others identified by the client as support people
- Understanding of the social, cultural and political issues that affect mental health and illness
- Knowledge of political activism

### *Goals of Community Mental Health Nursing*

- To provide prevention activities to populations for the purpose of promoting mental health.
- To provide interventions as early as possible.
- To provide corrective learning experiences for client-groups who have deficits and disabilities in the basic competencies needed to cope in society, and to help individuals develop a sense of self-worth and independence.
- To anticipate when populations become at risk for particular emotional problems and to identify and change social and psychological factors that diversely affect people's interaction with their environments.
- To develop innovative approaches to primary prevention activities.
- To assist in providing mental health education to populations about mental health and illness and to teach people how to assess their mental health.

### *Community Mental Health Nursing Process*

#### **Assessment**

The key aspects of assessment include:

- Impairments directly due to the psychiatric disorder such as persistent hallucinations, negative symptoms, social withdrawal, underactivity and slowness.
- Secondary social disadvantages such as unemployment, poverty and homelessness, as well as the stigma attached to psychiatric illness.
- Personal reactions to illness and social disadvantage such as low self-esteem and hopelessness, poor motivation and capacity for self-management and performance of social roles.
- Unpredictable behavior, risk of harm to self and others, and liability to relapse.
- Financial position of the client.
- Availability of community resources.
- Social circumstances to which the patient is likely to return to.

The expected outcome of the assessment is a detailed outline of the person's present functioning, highest level of functioning, and the needed services.

#### **Intervention**

Community psychiatric nurses must approach interventions with flexibility and resourcefulness to meet the broad range of needs of the patients with continued mental deficits. Interventions cannot be directed only towards discrete psychiatric symptoms, but must also facilitate client's access to various community resources providing for basic needs such as housing, nutrition, etc.

Since people suffering from mental illness often remain in or return to the community following treatment, nurses must be able to assess the presence of continued mental health problems and plan and implement interventions within the confines of the resources available in the community.

Carr *et al* (1984) have identified the following roles for nurses working in community mental health services:

*Consultative role:* This means giving advice to other professionals in the community about the type and level of nursing care required for a given client group.

*Clinician role:* Providing direct nursing care to the patients in the community.

*Therapeutic role:* Employing psychotherapeutic and behavioral methods for management of patients.

*Assessor/researcher role:* The nurse may assess the care given to the client/client group, and may also assess the outcome of ongoing care programs.

*Educator:* Creating awareness in the community about mental health and mental illness with special focus on vulnerable groups.

*Trainer/Manpower facilitators:* Training of paraprofessionals, community leaders, school-teachers

and other care-giving professionals in the community.

*Manager/Administrator:* Management of resources, planning and coordination .

*Domiciliary care:* Services are provided to the client by visiting their homes. Services like administration of medications, assessment of the level of functioning and improvement of patients, monitoring of side-effects of drugs, counseling of patients and family members are offered at the client's home setting.

*Liaison role:* Nurses working in the community help the clients and the family members by bridging the gap between the client and the hospital, client and the employers and also by networking in the community for resource development.

*Preventive roles:* These preventive roles are under primary, secondary and tertiary levels.

*Other areas of community health psychiatric nursing are:*

- Social skills training
- Anxiety management and relaxation
- Assertive training
- Bereavement counseling
- Group meetings
- Community out-reach work services
- Child care services
- Adult care and elderly care services

### **Some Tips to be Kept in Mind When Working in the Community**

#### *1. Identification of Patients in the Community:*

Talk to important people like, village panchayat members, local leaders, teachers, educated youth, members of service agencies like, angawadi, mahila mandals, etc. and request them to tell you about individuals:

- who talk nonsense and act in a manner considered strange or abnormal
- who have become very quiet and do not talk or mix with other people
- who claim to hear voices or see things that others cannot hear or see

- who are suspicious and claim that others are trying to harm them
- who have become unusually cheerful, crack jokes and say that they are very wealthy and superior to others when it is not really so
- who have become very sad lately and cry without reason
- who talk about suicide or have made an attempt at suicide
- who get possessed by god or spirit or who are said to be the victims of black magic or evil power
- who are dull, mentally not grown up like others of their age and slow since birth

When you visit homes, enquire about members suffering from mental illness. Ask the above-mentioned questions tactfully without offending them and obtain information about the existence of a patient in them in that family, neighborhood or among their relatives.

When you go to a school, enquire from teachers and students about children who suffer from fits, behavioral and learning problems.

#### *2. Refer the patient immediately in the following conditions:*

- the patient is severely ill, violent or unmanageable at home
- history of recent head injury
- repeated convulsions (continuous or more than 3 times a day)
- disturbed behavior after delivery
- the client has attempted suicide or is threatening to commit suicide
- disturbed behavior in people with known diabetes or hypertension
- people who show abnormal behavior after taking alcohol or any other intoxicating substances

#### *3. Follow-up care with special emphasis on medication regimen, improvement made, and side-effects, patient's occupational function*

- Is mental illness hereditary?

- Is mental illness contagious?
- Do ghosts, black magic, curse cause mental illness?
- Is mental illness treatable?
- Can patients take up responsibilities after recovery?
- Can marriage cure mental illness?

#### **Is mental illness hereditary?**

The role of genetic factors is well established only in some psychiatric illnesses (e.g. Schizophrenia, Mania and Depression). It is also not true that if a family member is suffering from Schizophrenia, the other members will always develop the same illness. The chances are more but the factors such as personality and environmental factors play an equally important role.

#### **Is mental illness contagious?**

Mental illnesses do not spread through contact of any form. Individual genetic vulnerability or predisposition and precipitating factors play an important role in disease occurrence.

#### **Do ghosts, black magic, curse cause mental illness?**

Many people consider that mental illness is not an illness, but possession by ghost or supernatural power. The causation of most of the mental illnesses is well known and specific methods are available to treat mental illnesses.

#### **Is mental illness treatable?**

80% of the mental illnesses are fully curable and preventable. Excluding Schizophrenia, all other mental illnesses can be easily controlled and prevented through proper medications and psychological therapies.

#### **Can patients take up responsibilities after recovery?**

Like other physical illnesses mental illnesses are curable with drugs and other physical and psychological methods.

Depression and mania are self-limiting illnesses, lasting from 6 to 9 months. Anxiety neurosis, hysteria etc. are fully curable and preventable disorders. If schizophrenia is

managed early and correctly, the patient may become socially and occupationally normal within few weeks.

#### **Can marriage cure mental illness?**

A mentally ill person can get worse if he gets married when he is ill, as marriage can become an additional stress. A patient who has recovered can get married and live a normal life like any other person.

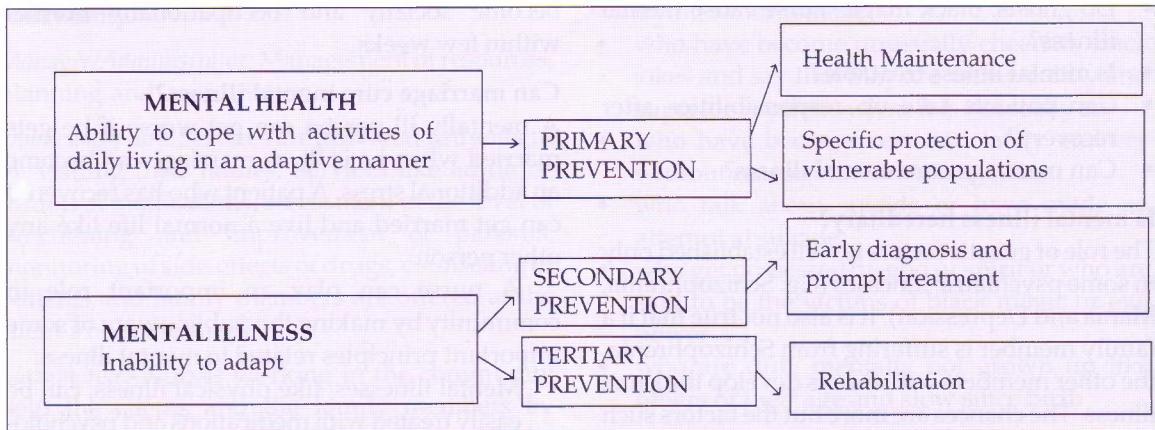
A nurse can play an important role in community by making the public aware of some important principles related to mental illness:

- Mental illnesses, like physical illness, can be easily treated with medications and psychological methods.
- The treatment of mental illness is not just confined to drugs; it also includes many other psychological therapies like behavior modification therapy, counseling, activity therapy, family therapy, group therapy etc.
- Continuity of treatment is more important for curing mental illnesses. Treatment should never be tampered without the advice of a psychiatrist.
- In majority of mental illnesses e.g. Mania, depression and other neurotic disorders like dissociative disorder, patients completely recover without a residual effect, if the treatment is taken on a regular basis.
- Early detection and prompt treatment for mental illnesses gives better improvement in psychiatric patients, they can lead socially productive lives.

#### **5. Remember**

- do not give false assurances or make false promises; just tell them you will do your best to help them
- do not make any decisions for the family
- do not criticize or blame
- see that they develop confidence in their abilities
- do not make them dependent on you
- avoid half-hearted attempts; hard work yields good results

### Levels of Prevention



(This paradigm was developed by Bloom, 1979)

### LEVELS OF PREVENTION AND ROLE OF A NURSE

In the 1960s, psychiatrist Gerald Caplan described levels of prevention specific to psychiatry. He described *primary prevention* as an effort directed towards reducing the incidence of mental disorders in a community. *Secondary prevention* refers to decreasing the duration of disorder while *tertiary prevention* refers to reducing the level of impairment.

#### Primary Prevention

Primary prevention seeks to prevent the occurrence of mental disorders by strengthening individual, family and group coping abilities.

#### Role of a Nurse in Primary Prevention

Community mental health nurses are in a key position to identify individual, family and group needs, conflicts and stressors. Thus they play a major role in identifying high-risk groups and preventing the occurrence of mental illness in them. Some interventions include :

##### 1. Individual centered intervention

- Antenatal care to the mother and educating her regarding the adverse effects of irradiation, certain drugs and prematurity.

- Ensuring timely and efficient obstetrical assistance to guard against the ill effects of anoxia and injury to the newborn at birth.
- Dietary corrections to those infants suffering from metabolic disorders.
- Correction of endocrine disorders.
- Liberalization of laws regarding termination of pregnancy, when it is unwanted.
- Training programs for physically, and mentally handicapped children like blind, deaf, mute and mentally subnormal etc.
- Counseling the parents of physically and mentally handicapped children, with particular reference to the nature of defects. The parents need to accept the child and emotionally support the child and be satisfied with limited goals in the field of achievement.
- Fostering bonding behaviors. Explaining importance of warm, accepting, intimate relationship and avoiding the prolonged separation of mother and child are essential.

##### 2. Interventions oriented to the child in the school

- Teaching growth and development to parents and teachers.

- Identifying the problems of scholastic performance and emotional disturbances among school children and giving timely intervention. School teachers can be taught to recognize the beginning symptoms of problems and referring to appropriate agencies.
3. Family centered interventions to ensure harmonious relationship
- Consulting with parents about appropriate disciplinary measures.
  - Promoting open health communication in families.
  - Rendering crisis counseling to the parents of physically and mentally handicapped children.
  - Ensuring harmonious relationship among members of the family and teaching healthy adaptive techniques at the time of stress producing events.
4. Interventions oriented to keep families intact
- Extending mental health education services at Child Guidance Clinics about child rearing practices; at parent-teacher associations regarding the triad relationship between teacher, child and parent; and at various extramural health agencies regarding integration of mental health into general health practice.
  - Strengthening social support for the frustrated aged and helping them to retain their usefulness.
  - Promoting educational services in the field of mental health and mental hygiene.
  - Developing parent-teacher associations.
  - Rendering home-maker services – when there is absence of the mother from home due to illness or other reasons for prolonged periods, the public health nurse can arrange for the service.
  - Providing marital counseling for those having marital problems.
5. Interventions for families in crisis
- In developmental crisis situations such as the child passing through adolescence, birth of a new baby, retirement or menopause, death of a wage earner in the family, desertion by the spouse etc. crisis intervention can be given at
- Mental hygiene clinics
  - Psychiatric first-aid centers
  - Walk-in clinics
6. Mental health education
- Conduct mass health education programs through film shows, flash cards and appropriate audio-visual aids regarding prevention of mental illnesses and promotion of mental health in the community.
  - Educate health workers regarding prevention of mental illness so that they can function effectively in all the areas of prevention.
7. Society-centered preventive measures
- Community development  
Culturally deprived families need biological and psychosocial supplies. They need better hygienic living conditions, proper food, education, health facilities, and recreational facilities. Otherwise, psychopathy, alcoholism, drug addiction, crime and mental illness, will result in such situations.
  - Collection and evaluation of epidemiological, biostatistical data.

### **Secondary Prevention**

Secondary prevention targets people who show early symptoms of mental health disruption but regain premorbid level of functioning through aggressive treatment.

#### *Role of a Nurse in Secondary Prevention*

- Early diagnosis and case finding : This can be achieved by educating the public, community leaders, industrialists, Mahila mandals, Balwadis etc. in how to recognize early symptoms of mental illness. Case finding through screening and periodic examination of population at risk, monitoring of clients etc. Thus in clinics, schools, home health care and the work place, community mental health

nurses detect early signs of increased levels of anxiety, decreased ability to cope with stress and failure to perceive self, the environment and/or reality accurately, and provide direct services as appropriate.

- Early reference : The public should be educated to refer these cases to proper hospitals as soon as they recognize early symptoms of mental illness.
- Screening programs : Simple questionnaires should be developed to identify the symptoms of mental illness, and administration of the same in the community for early identification of cases. These questionnaires can be simplified in local languages, and used widely in the colleges, schools, industries etc.
- Early and effective treatment for patient, and if necessary, to family members as relevant; providing counseling services to caregivers of mentally ill patients.
- Training of health personnel : Orientation courses should be provided to health workers to detect cases in the course of their routine work.
- Consultation services : Nurses working in general hospitals may come across various conditions such as puerperial psychosis, anxiety states, peptic ulcer, ulcerative colitis, bronchial asthma etc. These basic care providers need guidance and consultation to deal with these conditions in an effective manner.
- Crisis intervention : If crisis is not tackled in time it may lead to suicide or mental disorders. Sometimes anticipating the crisis situation and guiding the individual in time can help them to cope with the crisis situation in a better way.

### Tertiary Prevention

Tertiary prevention targets those with mental illness and helps to reduce the severity, discomfort and disability associated with their illness. In these terms community mental health nurses play a vital role in monitoring the progress of

discharged patients in halfway homes, houses etc., especially with regard to their medication regimen, coordination of care etc.

#### *Role of a Nurse in Tertiary Prevention*

- Family members should be involved actively in the treatment program so that effective follow-up can be ensured.
- Occupational and recreational activities should be organized in the hospital so that idling is prevented.
- Community based programs can be launched through meeting with the family members when the need for discharge from the hospital should be emphasized. These programs can be implemented through day hospitals, night hospitals, after care clinics, half-way homes, ex-patient hostels, foster care homes etc. Follow up care can be handed over to community health nurses.
- There should be constant communication between the community health nurses and the mental health institution regarding the follow up of the discharged patient. The ultimate aim of the hospital and community based programs is to re-socialize and re-motivate the patient for a functional role in the community, consistent with his resources.
- There are a wide range of services that need to be provided to patients as part of the tertiary prevention program. Nurses need to be familiar with the agencies in the community that provide these services. Collaborative relationships between mental health care providers and community agencies are absolutely essential if rehabilitation is to succeed.
- An important intervention in the maintenance of patients in their own homes in the community is the Training in Community Living (TCL) program, designed by 'Stein and Test'. In this model when a person is referred for a hospital admission the staff goes to the community with him rather than his going to the hospital to be with the staff. This real world experience with the patient enables the nurse

to assess accurately the skills that the person needs to learn and to mutually agree on realistic goals.

- Another aspect of community life that is more difficult to assess accurately and deal with effectively, is the stigma attached to mental illness. Many patients and their families try to avoid stigma by keeping the nature of the person's illness a secret. The need for secrecy places additional stress on the family system because there is always the fear that the truth will be revealed. Nurses in the community are in a key position to monitor community attitudes and help in fostering a realistic attitude towards the mentally ill.
- For some patients, the emotional climate of the family to which they return can have a significant effect on their adjustment, and eventually recovery from the debilitating effects of chronic mental illness. Families sometimes view mental illness as a weakness of character that can be overcome by exertion of moral effort. This type of familial attitude may result in guilt on the part of the patient who believes that he has disappointed his significant others. Guilt leads to increased anxiety and decreased self-esteem. These are the conditions that interfere with a high level of functioning. Therefore nurses working with families need to foster healthy attitudes towards the mentally ill member.

## PSYCHIATRIC REHABILITATION

Rehabilitation is the process of enabling the individual to return to his highest possible level of functioning. It is an important component of the community mental health program, and is undertaken at the level of tertiary prevention.

### Definition

Rehabilitation is "an attempt to provide the best possible community role which will enable the patient to achieve the maximum range of activity, interest and of which he is capable".

—Maxwell Jones [1952]

The following disorders are indicated commonly for rehabilitation:

- Chronic schizophrenia
- Chronic organic mental disorders
- Mental retardation
- Alcohol and drug dependence

### Principles of Rehabilitation

- Increasing independence would be the first step in rehabilitation process.
- Primary focus is on improvement of capabilities and competence of clients with psychiatric problems.
- Maximum use must be made of residual capacities.
- Patient's active participation is very essential.
- Skill development, therapeutic environment are fundamental interventions for a successful rehabilitation process.

### Psychiatric Rehabilitation Approaches

- a. Psychoeducation: Includes diagnosing the problem, telling the person what to expect regarding illness and discussing treatment alternatives.
- b. Working with families: Encouraging family members to get involved in treatment and rehabilitation programs.
- c. Group therapy: Positive aspects of group therapy include an opportunity for ongoing contact with others, validation of their perceptions, sharing their views about problems and problem solving abilities.
- d. Social skills training: It involves teaching specific living skills that the patient is expected to have in order to survive in the community.

### Rehabilitation Team

Professionals contributing to psychiatric rehabilitation include, psychiatrist, clinical psychologist, psychiatric social worker, psychiatric nurse, occupational therapist, recreational therapist, counselor and other mental health paraprofessionals.

### Steps in Psychiatric Rehabilitation

Psychiatric rehabilitation begins with a comprehensive medical psychiatric diagnosis and functional assessment. These are key elements in identifying impairments and disabilities. The steps of rehabilitation include:

- a. *Reduction of impairments:* Rehabilitation interventions with psychiatric patients require reduction or elimination of the symptoms and cognitive impairments that interfere with social and vocational performance. These impairments are reduced and eliminated for the greater part by various psychotropic agents.
- b. *Remediation of disabilities through skill training:* Skill training is used to remediate disabilities in social, family and vocational functioning. Patients generally require training in self-care skills, interpersonal skills, vocational and employment pursuits, recreational and leisure skills.
- c. *Remediating disabilities through supportive interventions:* When restoration of social and vocational functioning through skills training is limited by continuing deficits, rehabilitation strategies aim at helping the individuals compensate for handicap by learning skills in living and working environments, adjusting the individual and family expectations to a level of functioning that is realistically attainable.
- d. *Remediation of handicaps:* In addition to clinical rehabilitation interventions, the disabled persons can be helped to overcome their handicaps through social rehabilitation interventions, e.g. community support programs.

### Role of a Nurse in Psychiatric Rehabilitation

Rehabilitative psychiatric nursing must be studied in the context of both the patient and social system. This requires the nurse to focus on three elements, the individual, family and community.

### Assessment

#### *Assessment of the Individual*

The nurse should assess the individual in the areas of symptoms present, motivation, strengths,

interpersonal skills, self-esteem, activities of daily living and drug compliance.

#### *Assessment of Family*

Components of family assessment:

- Family structure including developmental stages, roles, responsibilities, norms and values.
- Family attitudes towards the mentally ill member.
- Emotional climate of the family.
- Social support available to the family.
- Past family experiences with mental health services.
- The family's understanding of the patient's problems and the plan of care.

#### *Assessment of Community*

It includes assessment of community agencies that provide services to people who have mental illnesses, assessment of attitudes of the people towards the mentally ill, etc.

### Planning and Implementation

Planning and implementation in rehabilitative psychiatric nursing focuses on fostering independence by maximizing personal strengths. The nurse and the patient must work together to find ways for the patient to overcome any remaining impaired areas of functioning.

#### *Individual Interventions*

Hospital rehabilitation (Inpatient rehabilitation): This involves therapeutic community, recreational therapy, social skills training and training in basic living skills.

Community rehabilitation: Providing care in community settings (Homes, residential care settings foster homes etc).

#### *Family Interventions*

- Health education to family members regarding the disease process, available resources,

- communication skills and problem solving techniques.
- Motivating the family members to provide proper care to the patient.
  - Group therapy and support to family members through self-help groups; nurses are in a favorable position to help families cope with stress and adapt to changes in the family structure.

### *Community Interventions*

There are several ways that nurses can intervene in the community tertiary prevention programs. Among these are health education to the public, training to school teachers, village leaders and paraprofessionals in the rehabilitation of mentally ill people.

### **Evaluation**

Evaluation of psychiatric rehabilitation services usually takes place at the level of impact on the patient, family and the effectiveness of the community service system.

### **Vocational Rehabilitation**

Vocational rehabilitation is a part of continuous and coordinated process of rehabilitation which involves the provision of those vocational services (e.g. vocational guidance, vocational training and selective placement) designed to enable a disabled person secure and retain suitable employment.

#### *Main Vocational Rehabilitation Centers in India*

- Mithra Special School and Vocational Training Center for the Mentally Retarded, Chennai.
- Banyan, Chennai.
- Vocational Rehabilitation Center, Chennai.
- Shristi Center for Psychiatric Rehabilitation, Madurai.
- VTC (Vocational Training Center) for the physically handicapped run by the Ministry of Labor, Government of India, has opened up its facility for the mentally ill for the first time in Chennai.

- Indian Red Cross Society (IRCS) which runs VTC for the handicapped has offered vocational training for the chronic mentally ill.
- Indian Council for Child Welfare, an NGO caring for underprivileged children.

#### *Phases in Vocational Rehabilitation*

- Vocational assessment  
 Vocational counseling  
 Vocational training  
 Job exploration  
 Job placement  
 Follow-up

#### *Vocational Assessment*

It is done in four areas viz., clinical, social, psychological and vocational.

- Clinical assessment includes assessing for residual psychiatric symptoms which may affect his ability to function.
- Social assessment includes assessing family support, attitude of family members and economic status of the family.
- Psychological assessment includes assessing self-esteem, confidence, patient's level of motivation.
- Vocational assessment includes assessing physical strength, hand coordination, attention, concentration, etc.

#### *Vocational Counseling*

This includes informing patients and family members regarding the type of training available. Family consent should be taken for rehabilitation training.

#### *Vocational Training*

It includes:

- Course content
- Duration of training
- Incentives
- Assessment of the progress
- Imparting skills
- Supervision

**Job Exploration**

Finding out various jobs available in the community.

**Job Placement**

This includes selecting suitable job, placement of the client in the job, checking the facilities available and evaluating work performance.

**Follow-up**

It includes evaluation of the four dimensions viz., clinical, social, psychological and vocational.

**Vocational Program**

*Open competitive job placement:* Though it is difficult to place the mentally restored in open competitive job placements, it is also possible to provide this opportunity for selected groups of patients with the clinical diagnoses of reactive psychosis, bipolar affective disorders, and acute psychotic episodes. They can be equipped to function successfully by regular follow-up programs.

*Sheltered employment:* This is provided for those disabled persons, who, because of the nature and severity of the disability, cannot cope with ordinary employment. This is suitable for those with the problems of mental retardation, chronic mental illness (e.g. schizophrenia, repeated attacks of affective disorder in spite of regular medication).

*Self-employment:* Persons who cannot cope with the demands of vocational adjustment in open competitive job situations, but who have the capacity to do some work with the help of any family members, may be considered for self-employment schemes which are usually sponsored by different welfare schemes of nationalized banks and social welfare departments.

*Home-bound work programs:* For those disabled needing total care, work can be given at home, which shall be collected by the center and paid according to the performance.

**NATIONAL MENTAL HEALTH PROGRAM**

The National Mental Health Program was launched in 1982 in India and aims to provide mental health care to the total population within the available resources.

**Objectives**

- Basic mental health care to all the needy especially the poor from rural, slum and tribal areas.
- Application of mental health knowledge in general health care and in social development.
- Promotion of community participation in mental health service development and increase of efforts towards self-help in the community.
- Prevention and treatment of mental and neurological disorders and their associated disabilities.
- Use of mental health technology to improve general health services.
- Application of mental health principles in total national development to improve quality of life.

**Approaches**

- Integration of mental health care services with the existing general health services.
- Utilization of the existing infrastructure of health services and also deliver the minimum mental health care services.
- Provision of appropriate task-oriented training to the existing health staff.
- Linkage of mental health services with the existing community development program.

**Components**

I. *Treatment*

Multiple levels were planned.

- A. Village and sub-center level multipurpose workers (MPW) and health supervisors (HS), under the supervision of medical officer (MO) to be trained for:
  - a. management of psychiatric emergencies

- b. administration and supervision of maintenance treatment for chronic psychiatric disorders
  - c. diagnosis and management of grandmal epilepsy, especially in children
  - d. liaison with local school teachers and parents regarding mental retardation and behavioral problems in children
  - e. counseling in problems related to alcohol and drug abuse
- B. MO of Primary Health Centre (PHC) aided by HS, to be trained for:
- a. supervision of MPW's performance
  - b. elementary diagnosis
  - c. treatment of functional psychosis
  - d. treatment of uncomplicated cases of psychiatric disorders associated with physical diseases
  - e. management of uncomplicated psychosocial problems
  - f. epidemiological surveillance of mental morbidity
- C. District hospital: It was recognized that there should be at least one psychiatrist attached to every district hospital as an integral part of the district health services. The district hospital should have 30-50 psychiatric beds. The psychiatrist in a district hospital was envisaged to devote only a part of his time to clinical care and a greater part in training and supervision of non-specialist health workers.
- D. Mental hospitals and teaching psychiatric units: Major activities of these higher centers of psychiatric care include:
- a. help in care of 'difficult' cases
  - b. teaching
  - c. specialized facilities like, occupational therapy units, psychotherapy, counseling and behavioral therapy

### *II. Rehabilitation*

The components of this sub-program include treatment of epileptics and psychotics at the community levels and development of rehabilitation centers at both the district level and higher referral centers.

### *III. Prevention*

The prevention component is to be community-based, with initial focus on prevention and control of alcohol-related problems. Later on, problems like addictions, juvenile delinquency and acute adjustment problems like suicidal attempts are to be addressed.

### **REVIEW QUESTIONS**

- Community facilities available for mentally ill patients (Nov 1999, Nov 2000, Nov 2001)
- Mental health services (Apr 2002, Nov 2002)
- Halfway homes (Feb 2000, Nov 2002)
- Self-help groups
- Role of a nurse in community mental health (Feb 2000)
- Levels of prevention (Nov 2001, Nov 2003)
- Role of a nurse in prevention of psychiatric disorders (Feb 2001, Nov 2003, Oct 2005, Apr 2006)
- Primary prevention (Nov 2003)
- Tertiary prevention (Oct 2004)
- Role of nurse in psychiatric rehabilitation (Oct 2005)
- Vocational rehabilitation
- National mental health program
- Enumerate the therapeutic activities of a nurse in community mental health care (Oct 2004)

# 18

## *Psychiatric Emergencies*

- COMMON PSYCHIATRIC EMERGENCIES
  - Suicidal Threat
  - Violent or Aggressive Behavior or Excitement
  - Panic Attacks
  - Catatonic Stupor
  - Hysterical Attacks
  - Transient Situational Disturbances
- ORGANIC PSYCHIATRIC EMERGENCIES
  - Delirium Tremens
  - Epileptic Furor
  - Acute Drug Induced Extrapyramidal Syndrome
  - Drug Toxicity

Psychiatric emergency is a condition wherein the patient has disturbances of thought, affect and psychomotor activity leading to a threat to his existence (suicide), or threat to the people in the environment (homicide). This condition needs immediate intervention to safeguard the life of the patient, bring down the anxiety of the family members and enhance emotional security to others in the environment.

### **COMMON PSYCHIATRIC EMERGENCIES**

- Suicidal threat
- Violent or aggressive behavior or excitement
- Panic attacks
- Catatonic stupor
- Hysterical attacks
- Transient situational disturbances

### **SUICIDAL THREAT**

In psychiatry a suicidal attempt is considered to be one of the commonest emergencies.

Suicide is a type of deliberate self-harm and is defined as an intentional human act of killing oneself.

### **Etiology**

#### *Psychiatric Disorders*

- Major depression
- Schizophrenia
- Drug or alcohol abuse
- Dementia
- Delirium
- Personality disorder

#### *Physical Disorders*

- Patients with incurable or painful physical disorders like, cancer and AIDS.

#### *Psychosocial Factors*

- Failure in examination
- Dowry difficulties
- Marital difficulties
- Loss of loved object
- Isolation and alienation from social groups
- Financial and occupational difficulties

#### *Risk Factors for Suicide*

- Age
  - males above 40 years of age
  - females above 55 years of age
- Sex
  - men have greater risk of completed suicide.
  - suicide is 3 times more common in men than in women.

- women have higher rate of attempted suicide
- Being unmarried, divorced, widowed or separated
- Having a definite suicidal plan
- History of previous suicidal attempts
- Recent losses

### Suicidal Tendency in Psychiatric Wards

Certain psychiatric disorders where the patient may develop suicidal tendencies include:

- *Major depression*: This is one of the commonest conditions associated with a high risk of suicide. Suicide in a major depressive episode is due to pervasive and persistent sadness; pessimistic cognitions concerning the past, present and future; delusions of guilt, helplessness, hopelessness and worthlessness; and derogatory voices urging him to take his life. The risk of suicide is more when the acute phase has passed and the characteristic psychomotor retardation has improved. This is so because the patient has more energy to carry out his suicidal plans now, though he might have been harboring them for quite some time.
- *Schizophrenia*: The major risk factors among schizophrenics include the presence of associated depression, young age and high levels of premorbid functioning (especially during college education). People in this risk group are more likely to realize the devastating significance of their illness more than other groups of schizophrenic patients do, and see suicide as a reasonable alternative.
- *Mania*: Manic patients may occasionally commit suicide. This is usually the result of grandiose ideation: the patient may believe that he is a great person, or wish to prove his supernatural powers. With this intent in mind, he may carry out some dangerous activity that can cost him his life.
- *Drug or alcohol abuse*: Suicide among alcoholics can be due to depression in the withdrawal phase. Also, the loss of friends and family, self-respect, status, and a general realization

of the havoc alcohol has created in his life can cause the individual to wish to die.

- *Personality disorder*: Individuals with histrionic and borderline traits may occasionally attempt suicide.
- *Organic conditions*: Conditions such as delirium and dementia due to changes of mood like anxiety and depression may also induce suicidal tendency.

### Management

1. Be aware of certain signs which may indicate that the individual may commit suicide, such as:
  - suicidal threat
  - writing farewell letters
  - giving away treasured articles
  - making a will
  - closing bank accounts
  - appearing peaceful and happy after a period of depression
  - refusing to eat or drink, maintain personal hygiene.
2. Monitoring the patient's safety needs:
  - take all suicidal threats or attempts seriously and notify psychiatrist
  - search for toxic agents such as drugs/ alcohol
  - do not leave the drug tray within reach of the patient, make sure that the daily medication is swallowed
  - remove sharp instruments such as razor blades, knives, glass bottles from his environment.
  - remove straps and clothing such as belts, neckties
  - do not allow the patient to bolt his door on the inside, make sure that somebody accompanies him to the bathroom
  - patient should be kept in constant observation and should never be left alone
  - have good vigilance especially during morning hours
  - spend time with him, talk to him, and allow him to ventilate his feelings

- encourage him to talk about his suicidal plans/methods
  - if suicidal tendencies are very severe, sedation should be given as prescribed
3. Encourage verbal communication of suicidal ideas as well as his/her fear and depressive thoughts. A 'no suicidal' pact may be signed, which is a written agreement between the client and the nurse, that client will not act on suicidal impulses, but will approach the nurse to talk about them.
4. Enhance self-esteem of the patient by focusing on his strengths rather than weaknesses. His positive qualities should be emphasized with realistic praise and appreciation. This fosters a sense of self-worth and enables him to take control of his life situation.

### **VIOLENT OR AGGRESSIVE BEHAVIOR OR EXCITEMENT**

This is a severe form of aggressiveness. During this stage, patient will be irrational, uncooperative, delusional and assaultive.

#### **Etiology**

- Organic psychiatric disorders like, delirium, dementia, Wernicke-Korsakoff's psychosis.
- Other psychiatric disorders like, schizophrenia, mania, agitated depression, withdrawal from alcohol and drugs, epilepsy, acute stress reaction, panic disorder and personality disorders.

#### **Management**

- An excited patient is usually brought tied up with a rope or in chains. The first step should be to remove the chains. A large proportion of aggression and violence is due to the patient feeling humiliated at being tied up in this manner.
- Talk to the patient and see if he responds. Firm and kind approach by the nurse is essential.
- Usually sedation is given. Common drugs used are: diazepam 10-20 mg, IV; haloperidol 10-20 mg; chlorpromazine 50-100 mg IM.
- Once the patient is sedated, take careful history from relatives; rule out the possibility

of organic pathology. In particular check for history of convulsions, fever, recent intake of alcohol, fluctuations of consciousness.

- Carry out complete physical examination.
- Send blood specimens for hemoglobin, total cell count, etc.
- Look for evidence of dehydration and malnutrition. If there is severe dehydration, glucose saline drip may be started.
- Have less furniture in the room and remove sharp instruments, ropes, glass items, ties, strings, match boxes, etc. from patient's vicinity.
- Keep environmental stimuli, such as lighting and noise levels to a minimum; assign a single room; limit interaction with others.
- Remove hazardous objects and substances; caution the patient when there is possibility of an accident.
- Stay with the patient as hyperactivity increases to reduce anxiety level and foster a feeling of security.
- Redirect violent behavior with physical outlets such as exercise, outdoor activities.
- Encourage the patient to 'talk out' his aggressive feelings, rather than acting them out.
- If the patient is not calmed by talking down and refuses medication, restraints may become necessary.
- Following application of restraints, observe patient every 15 minutes to ensure that nutritional and elimination needs are met. Also observe for any numbness, tingling or cyanosis in the extremities. It is important to choose the least restrictive alternative as far as possible for these patients.
- Guidelines for self-protection when handling an aggressive patient:
  - never see a potentially violent person alone.
  - keep a comfortable distance away from the patient (arm length).
  - be prepared to move, a violent patient can strike out suddenly.
  - maintain a clear exit route for both the staff and patient.

- be sure that the patient has no weapons in his possession before approaching him.
- if patient is having a weapon ask him to keep it on a table or floor rather than fighting with him to take it away.
- keep something like a pillow, mattress or blanket wrapped around arm between you and the weapon.
- distract the patient momentarily to remove the weapon (throwing water in the patient's face, yelling etc).
- give prescribed antipsychotic medications.

### PANIC ATTACKS

Episodes of acute anxiety and panic can occur as a part of psychotic or neurotic illness.

The patient will experience palpitations, sweating, tremors, feelings of choking, chest pain, nausea, abdominal distress, fear of dying, paresthesias, chills or hot flushes.

### Management

- Give reassurance first
- Search for causes
- Diazepam 10 mg or lorazepam 2 mg may be administered

### CATATONIC STUPOR

Stupor is a clinical syndrome of akinesis and mutism but with relative preservation of conscious awareness. Stupor is often associated with catatonic signs and symptoms (catatonic withdrawal or catatonic stupor). The various catatonic signs include mutism, negativism, stupor, ambivalence, echolalia, echopraxia, automatic obedience, posturing, mannerisms, stereotypies, etc.

### Management

- Ensure patent airway
- Administer IV fluids
- Collect history and perform physical examination
- Draw blood for investigations before starting any treatment

- Other care is same as that for an unconscious patient

### HYSTERICAL ATTACKS

A hysterical may mimic abnormality of any function, which is under voluntary control. The common modes of presentation may be .

- Hysterical fits
- Hysterical ataxia
- Hysterical paraplegia

All presentations are marked by a dramatic quality and sadness of mood.

### Management

- Hysterical fit must be distinguished from genuine fits (See p. 122 for differences between hysterical and epileptic seizures).
- As hysterical symptoms can cause panic among relatives, explain to the relatives the psychological nature of symptoms. Reassure that no harm would come to the patient.
- Help the patient realize the meaning of symptoms, and help him find alternative ways of coping with stress.
- Suggestion therapy with IV pentothal may be helpful in some cases.

### TRANSIENT SITUATIONAL DISTURBANCES

These are characterized by disturbed feelings and behavior occurring due to overwhelming external stimuli.

### Management

- Reassurance
- Mild sedation if necessary
- Allowing the patient to ventilate his/her feelings
- Counseling by an understanding professional

### ORGANIC PSYCHIATRIC EMERGENCIES

- Delirium tremens
- Epileptic furor
- Acute drug-induced extrapyramidal syndrome
- Drug toxicity

### **DELIRIUM TREMENS**

Delirium tremens is an acute condition resulting from withdrawal of alcohol (Refer p. 131 for details).

#### **Management**

- Keep the patient in a quiet and safe environment.
- Sedation is usually given with diazepam 10 mg or lorazepam 4 mg IV, followed by oral administration.
- Maintain fluid and electrolyte balance.
- Reassure patient and family.  
(see chapter 11 p. 132 for further details on management)

### **EPILEPTIC FUROR**

Following epileptic attack patient may behave in a strange manner and become excited and violent.

#### **Management**

- Sedation: Inj. Diazepam 10 mg IV [or] Inj. Luminal 10 mg. IV followed by oral anti-convulsants.
- Haloperidol 10 mg IV helps to reduce psychotic behavior.

### **ACUTE DRUG-INDUCED EXTRAPYRAMIDAL SYNDROME**

Antipsychotics can cause a variety of movement-related side-effects, collectively known as Extra Pyramidal Syndrome (EPS). Neuroleptic malignant syndrome is rare but most serious of these symptoms and occurs in a small minority of patients taking neuroleptics, especially high-potency compounds (refer chapter 14 p. 174 for a detailed description).

#### **Management**

The drug should be stopped immediately. Treatment is symptomatic and includes cooling the patient, maintaining fluid and electrolyte balance and treating intercurrent infections. Diazepam can be used for muscle stiffness. Dantrolene, a drug used to treat malignant hyperthermia, bromocriptine, amantadine and L-dopa have been used.

### **DRUG TOXICITY**

Drug over-dosage may be accidental or suicidal. In either case all attempts must be made to find out the drug consumed. A detailed history should be collected and symptomatic treatment instituted.

A common case of drug poisoning is lithium toxicity. The symptoms include drowsiness, vomiting, abdominal pain, confusion, blurred vision, acute circulatory failure, stupor and coma, generalized convulsions, oliguria and death.

#### **Management**

- Administer O<sub>2</sub>
- Start IV line
- Assess for cardiac arrhythmias
- Refer for hemodialysis
- Administer anticonvulsants

(see chapter 14 p. 177 for further details on lithium toxicity).

### **REVIEW QUESTIONS**

- List the common psychiatric emergencies
- Nursing management for a suicidal patient (Nov 1999)
- Nursing management for a violent patient
- Suicidal risk (Nov 2003)
- Suicide prevention (Oct 2004, Oct 2005)
- Management of aggressive patient (Apr 2004)

# 19

## *Psychosocial Issues Among Special Population*

- ADOLESCENT MENTAL HEALTH NURSING
- GERIATRIC MENTAL HEALTH NURSING
- PSYCHIATRIC DISORDERS RELATED TO WOMEN
- PSYCHOSOCIAL ISSUES AMONG HIV / AIDS PATIENTS

### **ADOLESCENT MENTAL HEALTH NURSING**

According to the World Health Organization (WHO), individuals between 10 -19 years of age come under the adolescent age group. Adolescence is a period of physical growth and intellectual attainment at its peak, coupled with setting of personality traits, decisions regarding future profession, and extreme emotional instability. This is also a period of identity crisis- physical, sexual and spiritual.

### **Mental Health Problems among Adolescents**

- Rates of depression, Bipolar Affective Disorders (BPAD), attempted suicide, completed suicide, conduct disorders and schizophrenia increase during adolescence.
- Antisocial activities increase in frequency.
- Agoraphobia and social phobia become more common during adolescence.
- The incidence of acting out behavior, and juvenile violent crime in adolescents continues to rise. Violent crimes include homicide, forcible rape, robbery or aggravated assault. Adolescents are especially at an increased risk of sexual abuse. In turn rape and sexual abuse are associated with a greatly increased risk of depression and suicide.
- Substance abuse usually starts during adolescent age.

- Co-morbidity or co-occurrence of psychiatric disorders e.g. adolescents with substance abuse disorders, are more likely to have comorbid disruptive behavior disorders. Comorbidity in adolescents is associated with impaired role functioning, likelihood of suicidal behavior, academic problems and increased conflict with parents.

### **Common Reasons for Mental Health Problems among Adolescents**

- Emotional difficulties in adolescents often arise from faulty or inconsistent child-rearing practices.
- Environmental factors such as poverty, lack of adequate support systems, major cumulative life stresses, and maternal employment influence coping abilities among children and adolescents.
- Constitutional factors or those characteristics within the adolescent affect the level of individual vulnerability.

### **Nursing Interventions**

- Nursing care of adolescents begins with a thorough assessment of their health status. Data collection by the nurse is based on current and previous functioning in all aspects of an adolescent's life. The data collection should include the following information
  - General appearance
  - Growth and development
  - General health status
  - Mental health status

- Cultural and socio-economic background
- Communication patterns (family, peers, society)
- Sexual behaviors and use of drugs, alcohol and other addictive substances
- Available human and material sources (friends, school and community involvement).
- Nurses need to understand normal adolescent development and also the difference between constructive and age-appropriate exploration and engagement in activities that are potentially dangerous to physical and emotional wellbeing.
- Nurses who work in schools and community settings can engage in screening and early nursing intervention with high risk teenagers to promote adaptive responses and prevent the development of future problems. Encouraging the adolescent to identify and discuss his/her feelings is extremely important in this regard.
- Nursing interventions useful in working with adolescents include health education, family, group and individual therapy and medication management. Emphasis should be laid on lifestyle and compliance issues, such as benefits of exercise, stress management and safer sex practices. Special attention should be given to talking with adolescents and working with their parents.
- Building a therapeutic relationship with an adolescent demands confidence and a strong sense of one's own identity or sense of comfort with one's memories of the teenage years. The nurse needs to offer unconditional acceptance and positive attitude and gentle encouragement for what the adolescent can become.

### **GERIATRIC MENTAL HEALTH NURSING**

Older adults are the most rapidly growing segment of the population. In India, life expectancy at birth has increased by about 20 years in the past 5 decades. The average life span today is 66 years. Today there are about 77 million aged people in India (i.e. above 60 years of age).

In Karnataka out of a population of 5.5 crores, 8% are elderly citizens. The 1st of October every year is observed as World Elders' Day globally. (*The Indian Express* 01st Oct. 2002)

WHO report of 2004 states that 236 elderly people per 10,000 suffer from mental illness mainly due to stress, heart disease, stroke and cancer. Dementia, a crippling disorder of old age, currently affects 1 in 20 people over 65 years of age in our country. It is projected that by the year 2025, 4 million Indians will become victims of dementia (*The Hindu*, 16th Feb. 2003, p.6).

Elderly individuals usually face a higher risk of developing mental as well as physical morbidity. Their vulnerability to mental problems is due to ageing of the brain, physical problems, socio-economic factors, cerebral pathology, emotional attitude and family structure. The biochemical and morphological changes in the aging brain of normal individuals are similar to those suffering from dementia. In most cases, mental illnesses coexist alongside physical problems in elderly individuals. Chronic physical disorders and sensory impairments (vision and hearing defects) are known to be especially associated with mental problems of the elderly.

### **PROBLEMS OF THE ELDERLY**

#### **Physical**

Ageing is a natural progressive decline in body systems. Physical changes include wrinkling of skin, flabbiness of muscles, atrophy of viscera, decreased vision and hearing, and a loss in efficiency of cardiovascular system. Old people suffer from immobility, instability, incontinence and intellectual impairment. These are called as the Giants of Geriatrics. These disabilities do not kill, but they greatly diminish the value of living.

#### **Psychiatric**

- Delirium, dementia, depression, agitation
- Crying spells, irritability, wandering, assaultiveness
- Expressions of feeling of worthlessness, hopelessness, helplessness

- Diminished memory, orientation and judgment
- Apathy, withdrawal, suicidal impulses or attempts, loneliness
- Paranoid delusions, demanding behavior, anxiety disorders
- Alcohol abuse, impaired concentration, short attention span
- Stress incontinence

### **Personality Changes**

These may occur due to psychoses with cerebral arteriosclerosis, senile dementia. Personality breakdown in old may lead to criminal behavior or suicidal tendencies.

### **Psychosocial**

The theme of this age period is loss, and dealing with death is one of the tasks of the elderly. Since death is the only certainty in life, without adequate emotional support to sustain and bear the losses (loss of work role, spouse, friends, sensory and motor abilities and intellectual processes), the elderly individual is vulnerable to depression and despair.

Social problems include harassment, ill-treatment, exploitation, desertion, separation from dear ones, living alone and none to help, etc.

### **Some therapies in the management of geriatric disorders include:**

#### *Somatic Therapies*

- Electro convulsive therapy
- Psychopharmacology

#### *Psychological Therapies*

- Psychotherapy
- Life review therapy
- Reality orientation therapy
- Validation therapy
- Cognitive training
- Relaxation therapy
- Counseling
- Patient and family education

### **Nursing Management**

- The nurse who works with mentally ill elders is challenged to integrate psychiatric nursing skills with knowledge of physiological disorders, the normal ageing process and socio-cultural influences on the elderly and their families
- The goal of nursing intervention is to promote maximum independence of the older adults, based on capacity and functional abilities
- The role of geropsychiatric nurse includes providing primary mental health nursing care, including intervening with caregivers, providing case management and consulting with other care providers. Advanced practice nurses provide individual and group psychotherapy
- The nurse should be proficient at assessing patient's cognitive, affective, functional, physical and behavioral status, as well as their family dynamics
- Geropsychiatric nurses should be knowledgeable about the effects of psychotropic medication on elderly people. Nurses often work closely with the physician to monitor complex medication regimens and assist the patients and caregivers with medication management
- The key concepts of geropsychiatric nursing assessment include
  - Mental health status examination (it includes mini-mental status examination, mental status examination, depression, anxiety and psychosis)
  - Frequently observed problem behavior
  - Functional abilities
  - General health and
  - Social support system
- Nursing interventions with geropsychiatric patients include creation of a therapeutic milieu, involvement in somatic therapies, and interpersonal interventions. The basic characteristics of a therapeutic milieu are: cognitive stimulation, promotion of a sense of calm and quietness, consistent physical layout,

- structured routine, focus on strengths and abilities, minimizing of disruptive behavior, providing safety
- Care givers should be involved in planning, implementation and evaluation of nursing interventions.

## **PSYCHIATRIC DISORDERS RELATED TO WOMEN**

In most societies, psychiatric disorders are more common in women. The common reasons for this include: genetic differences, societal pressures on women, differences in rearing pattern and cultural expectations.

The mental disorders more commonly reported in females include major depression, neurotic depression, anxiety states, phobic neurosis, hypochondriasis, dissociative disorders, adjustment problems, attempted suicide, anorexia nervosa and senile dementia.

There are many psychiatric disorders peculiar to females which include :

- Premenstrual syndrome
- Psychiatric disorders associated with child birth
- Menopausal syndrome

## **I. PREMENSTRUAL SYNDROME**

Menstruation is a normal physiological process in females. The various psychological symptoms attributed to premenstrual syndrome are: sadness, anxiety, anger, irritability, labile mood, decreased concentration, indecision, suspiciousness, sensitivity, suicidal or homicidal ideations, insomnia, hypersomnia, anorexia, craving for certain foods, fatigue, lethargy, agitation, libido changes, decreased motivation, impulsivity and social withdrawal.

This premenstrual syndrome starts about 5 to 10 days before onset of menses and lasts till the end of menses. It not only affects social but also occupational functioning, leading to various degrees of maladjustments.

## **Management**

- The syndrome has been widely treated with progesterone, oral contraceptives, bromocriptine, diuretics and antidepressant drugs
- Psychological support and encouragement
- Cognitive behavior therapy

## **II. PSYCHIATRIC DISORDERS ASSOCIATED WITH CHILD BIRTH**

There is an increased risk of mental illness associated with childbirth, mostly in the postpartum period but problems may also be present before or during pregnancy.

- A. Mental illness in pregnancy
- B. Puerperal mental disorders

### **A. Mental illness in pregnancy**

The incidence of mental illness in the first trimester of pregnancy is thought to be high, when compared to second and third trimesters of pregnancy.

The predisposing factors for mental illnesses during pregnancy are; neurotic traits in premorbid personality, marital tension, history of previous abortion.

The majority of episodes of mental illness during pregnancy are neuroses. The commonest condition is depressive neurosis with anxiety, phobic anxiety and obsessive compulsive disorders. In most cases these conditions resolve by the second trimester of pregnancy.

The major mental illnesses in pregnancy include bipolar affective disorder, severe depression and schizophrenia. The risk of women developing a new episode of one of these conditions in pregnancy is lower than at other times in her life.

## **Management**

- The nurse should provide support, counseling, reassurance and information which is communicated in a caring, intelligible way.
- If the psychiatrist feels that there is a substantial risk of relapse if the women's

medications are withdrawn, then this risk has to be weighed against that of the drugs having a teratogenic effect on the fetus.

### **B. Puerperal Mental Disorders**

As many as 16% of mothers develop mental illness in the puerperium. The risk of becoming mentally ill during the puerperium is greater than at other times in the women's reproductive life.

Many factors are associated with puerperal mental illness such as lack of confiding relationship and support, marital tension, socio-economic problems and a previous psychiatric history.

Common puerperal mental disorders are :

- A. Postnatal blues
- B. Postnatal depression
- C. Puerperal psychosis

#### **a. Postnatal blues (transitory mood disorders)**

Postnatal blues are transient, a self limiting condition with no known serious after effects. Most women recover from the blues within a day or two. It occurs at any time between the third and tenth postnatal day. It is considered a normal reaction to childbirth and affects about 70% to 80% of all postnatal mothers. These are more common in primigravida and in those who complain of premenstrual tension.

The women experience unfamiliar episodes of crying, irritability, depression, emotional lability, feeling separate and distant from the baby, insomnia and poor concentration.

The support given to mothers in the postnatal period may help them to cope with their feelings and have a significant contribution to their emotional wellbeing and adaptation to motherhood.

#### **b. Postnatal depression**

Postnatal depression is the most frequent neurotic disorder during postnatal period. It occurs in 10% to 15% of women. Onset is usually within the first postpartum month, often on returning home and usually between day 3 and day 14.

A majority of women recover spontaneously. The depressive episodes are manifested as poor concentration, feeling of guilt, loss of energy, lack of interest in usual activities, social withdrawal, inability to cope, tiredness, irritability, anxiety, ruminative worry about the baby, guilt about their perceived poor mothering skills, sleep disturbances, depressive ideation and anomie (which is a painful feeling of inability to experience love or pleasure).

#### *Management*

- Counseling
- Cognitive therapy
- Antidepressants like amitriptyline and tetracyclic drugs
- Good supervision and support

#### **c. Puerperal Psychosis**

Puerperal psychosis affects approximately 1-2 per 1000 births. Unmarried status, primigravida, past history of schizophrenia may predispose to puerperal psychoses.

The onset is very sudden, commonly occurring within the first postnatal week. The main features are;

- Insomnia and early morning waking
- Lability of mood, sudden tearfulness or inappropriate laughter
- Abnormal behavior such as restlessness, excitement or sudden withdrawal
- Suspiciousness and fear
- Unexpected rejection of the baby or a conviction that baby is deformed or dead
- Suicidal or infanticide threats
- Excessive guilt, depression or anxiety

#### *Management*

- Puerperal psychosis is a psychiatric emergency. Admission to hospital is always required, due to the potential danger to the baby and difficulty in dealing with the mother's behavior at home
- Electroconvulsive therapy

- Antipsychotics -may cause over sedation in baby
- Supportive psychotherapy

### III. MENOPAUSAL SYNDROME

Menopause, the cessation of ovulation, generally occurs between 45 and 53 years of age. The hypoestrogenism that follows can lead to hot flashes; sleep disturbances, vaginal atrophy and dryness, and cognitive and affective disturbances like worrying, depression, anxiety, irritability, difficulty in concentration and decreased self confidence.

#### Management

- Hormonal replacement therapy
- Reassurance
- Psychological support
- Early identification of emotional problems and prompt treatment
- Counseling
- Psychotherapy

### PSYCHOSOCIAL ISSUES AMONG HIV / AIDS PATIENTS

HIV / AIDS is one of the most devastating global epidemics of the twentieth century. The Human Immunodeficiency Virus (HIV) and the resulting Acquired Immune Deficiency Syndrome (AIDS) include a variety of serious and debilitating disorders such as opportunistic infections resulting from a compromised immune system and significant co-occurring psychiatric illnesses. In India the number of people with the virus is 5.134 millions, according to the National AIDS Control Organization (NACO) estimate of 2005, with nearly 90 percent of cases in the 15 – 49 year age group (*The Indian Express*, 17<sup>th</sup> Aug. 2005, p-8). Karnataka and Tamil Nadu have the highest prevalence of HIV / AIDS cases. A 2004 survey estimated that 50,000 people in Karnataka were affected by the disease (*The Indian Express* 01<sup>st</sup> Dec. 2005, p-1).

### Psychosocial Issues Related to a Positive Result

1. **Emotional:** Shock, numbness, disbelief, confusion, uncertainty about present and future, denial, guilt, frequent changes of mood, sadness and concern about the future.
2. **Behavioral:** Crying, anger expressed verbally and physically, withdrawal, checking the body for signs of infection/deterioration.
3. **Fear:** Fear of pain, of death, of disability, loss of functioning, of loss of privacy/confidentiality, of desertion.
4. **Loss:** Of future and ambitions, of physical attractiveness and potency, of sexual relationship, of status in community, of independence, of control over life, of confidence.
5. **Guilt:** Guilt about the behavior that resulted in HIV infection, about infecting others, about disrupting the life of others.
6. **Grief:** Grief over the loss of health.
7. **Isolation:** Due to social stigma.
8. **Resentment:** At changes in living patterns.
9. **Depression:** Depression due to absence of a cure, loss of personal control.
10. **Anxiety:** Anxiety about prognosis, social, occupational, domestic and sexual hostility and rejection.
11. **Anger:** Anger about the helplessness of the situation, unfair fate, others who are infection-free, health care workers, others who discriminate.
12. **Suicidal thoughts and acts**
13. **Loss of self esteem:** Due to rejection, loss of confidence, loss of identity, physical impact of HIV infection.
14. **Obsession:** Due to pre-occupation with health
  - In some instances, a symptom complex similar to post-traumatic stress disorder is common in the first few weeks after notification of HIV positivity.
  - The person may become extremely anxious and hypervigilant about

physical symptoms, exhibiting marked dependence on health care providers.

- Other responses are, transient or chronic sexual dysfunction and social withdrawal due to fear of infecting others or of social rejection.
- Significant others of patients with HIV disease face a great many stresses associated with the patient's illness. They may experience grief response, financial concerns and lack of social support (due to stigma attached to illness).
- Many psychiatric syndromes are associated with HIV/AIDS. These are depression, anxiety, paranoia, mania, irritability, psychosis and substance abuse. They complicate immune system function, adversely affect the patient's ability to fully participate in treatment, and negatively impact the quality of life. On the whole, the diseases tax coping responses to the limit and beyond.

### Nursing Management

- Psychiatric nurses are in a unique position to help diagnosis, treat and support patients affected by HIV/AIDS.
- A thorough psychiatric history and complete neuropsychiatry evaluation are indicated when HIV positive patients present with psychiatric symptoms.
- Planning health care for person with HIV/AIDS must involve the multidisciplinary team.
- Interventions include case management, medications, risk reduction, support groups, crisis intervention, encouragement of productive activity, enhancement of self-esteem, grief counseling, support during terminal stages, and support of significant others.
- The psychiatric interventions for patients with HIV/AIDS are;
  - Helping patients change risky behavior, thus promoting prevention of HIV infection
  - Helping patients during the difficult process of HIV testing (pre and post-test counseling)

- Helping establish the diagnosis and treatment of other psychiatric illnesses commonly seen in patients with HIV
- Implementing psychosocial interventions like psychotherapy, cognitive behavioral therapy, counseling etc.
- Helping patients, their families and others in their lives with interpersonal problems related to HIV/AIDS
- Assisting AIDS patients during the final phase of their illness.

### Steps in Pre-test Counseling

- Assess the individual's motivation for testing
- Assess what information the person already has about HIV/AIDS
- Provide basic information regarding HIV in very simple terms
- Clarify/correct misconceptions, if necessary
- Describe the process of antibody testing
- Give information about the accuracy of tests
- Explain window period
- Explain what the test result means, i.e. in terms of being HIV positive, negative or indeterminate
- Discuss the issue of confidentiality
- Facilitate informed decision and consent for the test
- Review client's assessment of own risk
- Provide risk reduction information
- Assess the client's social network and coping strategies.

### Steps in Post-test Counseling

- Build rapport
- Reveal test result (never divulge the test result over the telephone)
- After disclosing that the test is positive, keep quiet for a while – let the patient react and ventilate his feelings; give him time to absorb the test result.
- Explore the patients understanding of the medical meaning of test
- Empathize to understand the way he feels

- Talk about the things he can do safely
- Provide information regarding precautions to avoid transmission
- Assess his commitment to reducing risk. If change is resisted, emphasize harm reduction
- Assess patients lifestyle - tell him how a few changes with regard to diet, substance abuse etc., will have to be made
- Develop a health plan
- Find out how he usually copes with stress; assess social support network available
- Explore and assist patient to face the consequences of having to declare HIV status to significant others e.g. spouse/sexual partners, family, health-care providers etc.
- Work with the families regarding their own anxieties about their own health or the future of the infected person. Provide counseling services to family members if so desired by the patient
- Some important instructions which must be communicated to a HIV+ patient includes :
  - Safe-sex information, correct use of condoms all the time
- Necessity to stop donating blood, donating organs, sharing needles, etc.
- Safety practices in HIV drug use, blood donation, tests, etc.
- Regular medical monitoring
- Safety tips to patients who work in jobs where they may infect others
- Need to discuss HIV infection with their sexual partner.

The level of support required to assist patients and others who deal with AIDS demands skilled interventions and an integrated team effort among mental health professionals including psychiatric nurses.

### REVIEW QUESTIONS

- Mental health problems among adolescents
- List the psychiatric problems among elderly people
- List the psychiatric disorders associated with child birth
- Describe psychosocial issues among HIV/ AIDS patients

# **Appendix I**

## *Glossary*

---

**Abreaction:** A treatment procedure whereby repressed painful experiences are voluntarily recalled to awareness. This ventilation gives a therapeutic effect.

**Abstract thinking:** Ability to appreciate nuances of meaning; multidimensional thinking with ability to use metaphors and hypotheses appropriately.

**Addiction:** Strong dependence, both physical and emotional, on alcohol or some other material.

**Affect:** A short-lived emotional response to an idea or an event.

**Agitation:** Presence of anxiety with severe motor restlessness.

**Ambivalence:** The co-existence of two opposing drives, desires, feelings or emotions towards the same person, object or goal; a conflict to do or not to do.

**Amnesia:** Pathological impairment of memory.

*Anterograde amnesia:* Amnesia of events occurring after the episode which precipitated the disorder.

*Retrograde amnesia:* Amnesia of events occurring prior to the episode which precipitated the disorder.

**Anhedonia:** Inability to experience pleasure in any activity.

**Apathy:** Lack of emotional feeling.

**Apraxia:** Inability to carry out normal activities despite intact motor function.

**Autistic thinking:** Preoccupations totally removing a person from reality.

**Automatic obedience:** The patient obeys every command though he has first been told not to do so.

**Automatism:** Undirected behavior that is not consciously controlled, as seen in complex partial seizures.

**Blunted affect:** A reduction in emotional experience.

**Cataplexy:** Temporary loss of muscle tone and weakness precipitated by a variety of emotional states.

**Catharsis:** The expression of ideas, thoughts and suppressed material accompanied by an appropriate emotional response that produces a state of relief in the patient.

**Circumstantiality:** A pattern of communication that is demonstrated by the speaker's inclusion of many irrelevant and unnecessary details in his speech before he is able to come to the point.

**Clang association:** Client uses two words with a similar sound, i.e. his choice of words is determined by their sound and not by their meaning, which often reduces the intelligibility of speech. It may lead to *punning* (humorous use of words to suggest different meanings) and *rhyming*, and is often seen in manic patients.

**Compulsion:** Pathological need to act on an impulse that, if resisted, produces anxiety; repetitive behavior in response to an obsession or performed according to certain rules, with no true end in itself other than to prevent something from occurring in the future (the patient fears something bad will occur in future if he does not indulge in such behaviors).

**Concrete thinking:** Thought processes are focused on specifics rather than generalizations. These individuals are unable to comprehend abstract meanings.

**Confabulation:** The unconscious filling of memory gaps by imagined or untrue experiences due to memory impairment. It is most often associated with organic pathology.

**Deja vu:** A subjective feeling that an experience, which is occurring for the first time, has been experienced before.

**Depersonalization:** A person's subjective sense of being unreal, strange or unfamiliar.

**Derealization:** A subjective sense that the environment is strange or unreal; a feeling of changed reality.

**Delusion:** A false, unshakeable belief, which is not amenable to reasoning and is not in keeping with the patient's sociocultural and educational background.

*Primary (Autochthonous) delusion* is one that appears suddenly and with full conviction, but without any previous events leading up to it. Such delusions are suggestive of schizophrenia.

*Secondary delusions* can be understood as derived from some preceding morbid experience.

**Delusional mood:** Occasionally, when a person first develops a delusion, the first experience is a change of mood, often a feeling of anxiety with the foreboding that some sinister event is about to take place, and the delusion follows. In German this change of mood is called *Wahnstimmung*, a term usually translated as *delusional mood*.

**Delusional perception:** In some occasions when a person first develops a delusion, the first change may be attaching a new significance to a familiar percept without any reason. For example, a new arrangement of objects on a colleague's desk may be interpreted as a sign that the patient has been chosen to do God's work. This is called *delusional perception*.

**Delusion of grandeur:** An individual's exaggerated conception of his importance, power or identity, a belief that he is somebody special, or is born with a special mission in life, or is related to the most important people of his time.

**Delusion of persecution:** A belief that he is being attacked, harassed, spied, cheated or conspired against.

**Delusion of reference:** It is the delusion that events, objects, behavior of others have got a particular or unusual significance for oneself, usually of a negative nature. For instance the person may falsely believe that others are talking about him (such as, the belief that people on television or radio are talking about the person).

**Delusion of control:** This refers to the belief that the patient's will, thoughts or feelings are being controlled by external forces.

**Delusion of infidelity (Delusion of jealousy):** This is the delusion that one's lover is unfaithful to him/her.

*Delusion of guilt:* Belief that one is a sinner and is responsible for the ruin of his family or society.

*Somatic delusion:* Belief involving functioning of the body. For example, belief that the brain is rotting or melting.

*Nihilistic delusion:* The delusional belief that others, oneself or the world do not exist. Most commonly seen in major depressive episode.

*Eerotomania:* A delusional belief that the other person is deeply in love with him/her. The supposed lover is usually inaccessible and of much higher social status (also known as Clerambault-Kandinsky Complex).

*Mood-incongruent delusion:* Delusion with content that has no association to mood or is mood neutral (for example a depressed patient has delusions of thought control or thought broadcasting).

*Mood-congruent delusion:* Delusion with mood appropriate content (for example, a depressed patient believes that he is responsible for the destruction of the world).

*Systematized delusion:* False belief or beliefs united by a single event or theme.

*Bizarre delusion:* An absurd, totally implausible, strange false belief in a person's mind.

*Echolalia:* Pathological repetition by imitation of the speech of another.

*Echopraxia:* Pathological repetition by imitation of the behavior of another.

*Egocentric:* Self-centered; preoccupied with one's own needs and lacking interest in others.

*Ego-dystonic:* Distressing to the individual.

*Flat affect:* Absence or near absence of any sign of affective expression; voice monotonous, face immobile.

*Flight of ideas:* The client's thoughts and conversation move quickly from one topic to another, so that one train of thought is not completed before another appears. These rapidly changing topics are understandable because the links between them are normal, a point that differentiates them from loosening of associations. Flight of ideas is characteristic of mania.

*Folie à deux:* A psychotic reaction in which two closely related persons, usually in the same family, mutually share the same delusions.

*Formal thought disorder:* Disturbance in the form of thought rather than the content of thought; thinking characterized by loosened associations, neologisms, and illogical constructions; thought process is disordered, and the person is defined as psychotic.

*Functional:* Having a psychological rather than an organic pathology.

*Geriatric psychiatry:* A speciality of psychiatry which deals with mental health problems of the elderly.

*Hallucinations:* A false sensory perception in the absence of an actual external stimulus. Hallucinations may be described in terms of their sensory modality as *visual, auditory, olfactory, gustatory, tactile*.

*Auditory hallucinations:* These are by far the commonest, and may be experienced as noise, music or voices. Voices may seem to address the patient directly (*second-person hallucinations*) or talk to one

another referring to the patient as 'he' or 'she' (*third-person hallucinations*). Third-person hallucinations may be experienced as voices commenting on the patient's intentions or actions. Such commentary voices are strongly suggestive of schizophrenia.

*Visual hallucination:* False perception involving sight consisting of both formed images (for example people) and unformed images (for example, flashes of light); most common in medically determined disorders.

*Olfactory hallucination:* False perception of smell; most common in medical disorders.

*Gustatory hallucination:* False perception of taste, such as unpleasant taste, caused by an uncinate seizure; most common in medical disorders.

*Tactile (Haptic) hallucination:* False perception of touch or surface sensation, as from an amputated limb (phantom limb); crawling sensation on or under the skin (formication).

*Somatic hallucination:* False sensation of things occurring in or to the body, most often visceral in origin (also known as cenesthetic hallucination).

*Mood-congruent hallucination :* Hallucination in which the content is consistent with either a depressed or a manic mood (for example depressed hears voices saying that the patient is a bad person; a manic hears voices saying that the patient is of inflated worth, power and knowledge).

*Mood-incongruent hallucination:* Hallucination in which the content is not consistent with either depressed or manic mood (for example in depression, hallucinations not evolving such themes as guilt, deserved punishment, or inadequacy; in mania, hallucinations not involving such themes as self-inflated worth or power).

*Command hallucination:* False perception of orders that a person may feel obliged to obey or unable to resist.

**Hypnagogic hallucinations:** These hallucinations occur when falling asleep, generally considered as non-pathological.

**Hypnopompic hallucinations:** Hallucinations occur when the subject is awakening, often occurring in healthy individuals.

**Hypochondriasis:** Exaggerated concern with one's physical health, not based on organic pathology.

**Illusion:** The misinterpretation of a real, external sensory experience.

**Insight:** Insight means the capacity to appreciate that one's disturbance of thought and feeling are subjective and invalid. Loss of insight has traditionally been considered to occur in psychosis, while its retention characterizes neurosis.

*Intellectual insight:* Understanding of the objective reality of a set of circumstances without the ability to apply the understanding in any useful way to master the situation.

*True insight:* Understanding of the objective reality of a situation, coupled with the motivation and the emotional impetus to master the situation.

**Intelligence Quotient (IQ):** Intelligence of a person measured through psychological testing. Normal IQ is 90-110; an IQ of below 70 denotes mental retardation.

**Illogical thinking:** Thinking containing erroneous conclusions and internal contradictions.

**Jamais vu:** Failure to recognize events that have been encountered before.

**Judgment:** Judgment is the mental act of comparing and evaluating alternatives for the purpose of deciding on a course of action. Judgment is said to be disturbed when the individual deviates from what is generally held as valid, and holds obstinately to its content although it interferes with his adaptation.

**Labile affect:** Rapidly shifting emotions, unrelated to external stimuli.

**Loosening of associations:** A pattern of spontaneous speech in which things said lack a meaningful relationship, or there is idiosyncratic shifting from one frame of reference to another; it is usually the general lack of clarity in the client's conversation that makes the most striking impression.

Loosening of association takes several forms:

*Knight's move or derailment* refers to a transition from one topic to another, either between sentences or in mid-sentence, with no logical relationship between the two topics. When this abnormality is extreme it disrupts not only the connections between sentences and phrases, but also the finer grammatical structure of speech. It is then called *word salad*. One effect of loosened associations on the client's conversation is sometimes called *talking past the point* (also known by the German term *vorbeireden*). In this condition the patient seems always about to get near to the matter in hand, but never quite reaches it. *Incoherence* is a marked degree of loosening of association in which the patient shifts ideas from one to another without logical connection and the patient's talk cannot be understood at all.

**Libido:** A term used in psychoanalytic theory for sexual drive.

**Malingering:** Deliberate simulation or exaggeration of an illness or disability that in fact is non-existent or minor.

**Manipulation:** A behavior pattern characterized by exploitation of interpersonal contact; indiscriminate use of interpersonal relationship to meet one's own end without any consideration for the other person in the relationship.

**Mannerism:** Ingrained, habitual involuntary movement.

**Munchausen Syndrome:** A disorder in which sufferers habitually attempt to hospitalize themselves with self-inflicted pathology.

**Narcissism:** Obsessive and exclusive interest in one's own self.

**Narcoanalysis:** A procedure by which a chemical is injected into a person (e.g. slow IV injection of pentathol), while encouraging him to ventilate the unconscious desires and motives which he cannot recollect during conscious state. It's a therapeutic and a diagnostic procedure commonly used in neurotic disorders.

**Negativism:** Motiveless resistance to all attempts to be moved or to all instructions.

**Neologism:** A word newly coined or an everyday word used in a special way, not readily understood by others.

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***Obsession:*** Pathological persistence of an irresistible thought or feeling that cannot be eliminated from consciousness by logical effort; associated with anxiety.

***Oedipus complex:*** Attachment of the child to the parent of the opposite sex, accompanied by envious feelings towards the parent of the same sex.

***Overvalued idea:*** Unreasonable, sustained false belief maintained less firmly than a delusion.

***Paranoid:*** An adjective applied to individuals who are over-suspicious.

***Para suicide (Deliberate self-harm):*** Any act deliberately undertaken by a person which mimics the act of suicide, but which does not result in a fatal outcome.

***Passivity phenomenon:*** The delusional belief that an external agency is controlling the self.

***Phobia:*** Persistent, irrational, exaggerated and invariably pathological dread of a specific stimulus or situation; results in a compelling desire to avoid the feared stimulus.

***Pressure of speech:*** Rapid production of speech output, with a subjective feeling of racing thoughts.

***Perseveration:*** Persistent repetition of words or themes beyond the point of relevance.

***Poverty of speech:*** Decreased speech production.

***Pseudodementia:*** Similar clinically to dementia, but has a non-organic cause and is reversible.

***Psychometry (Psychological testing):*** The science of testing and measuring mental and psychological ability, efficiency, potentials and functioning.

***Psychopathology:*** The study of significant causes and processes in the development of mental disorders.

***Rapport:*** Establishing a meaningful conversation.

***Rorschach test:*** A psychological test to disclose conscious and unconscious personality traits and emotional conflicts by eliciting patients' associations to a standard set of inkblots.

***Somatic delusion:*** The belief that one's body is changing and responding in some unusual way.

***Stereotypes:*** Persistent mechanical repetition of speech or motor activity.

***Stupor:*** A state in which the individual does not react to his surroundings and appears to be unaware of them. Commonly seen in catatonic and depressive disorders.

***Tangentiality:*** A form of thinking/speech in which the client tends to wander away from the intended point, and never returning to the original idea.

***Thematic apperception test (TAT):*** A psychological test used as a diagnostic tool consisting of 30 cards, to assess personality and psychopathology.

***Thought block:*** A sudden interruption in the thought process before the thought is completed. After a pause, the subject cannot recall what he had meant to say. This may be associated with thought withdrawal. Thought block is strongly suggestive of schizophrenia.

***Thought broadcast:*** The delusional belief that one's thoughts are being broadcast or projected into the environment.

**Thought insertion:** The delusional belief that thoughts are being put into one's mind. These thoughts are recognized as being foreign.

**Thought withdrawal:** The delusional belief that one's thoughts are taken away by some external agent, often associated with thought block.

**Transference:** A process in which feelings, attitudes and wishes originally linked with significant figures in one's early life are projected onto the therapist.

**Verbigeration:** Senseless repetition of some words or phrases over and over again.

**Wechsler Intelligence Scale:** A test for assessing intellectual functioning.

**Word approximation (Paraphasias):** Commonly used words used in a new or unconventional way. Often the meaning is evident though the usage may be peculiar (for example, describing 'stomach' as 'food vessel').

## **Appendix II**

### **Mental Mechanisms**

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Every individual has devices for protecting himself against psychological dangers and distress. These protective devices are known as ego defences or defence mechanisms or mental mechanisms. Both well-adjusted and maladjusted individuals make use of these mechanisms in their daily behavior. While well-adjusted individuals use them sparingly and in socially desirable ways, maladjusted individuals including psychotics and neurotics, use them frequently and inappropriately.

Some of the commonly used mental mechanisms are:

**Repression:** It is a process of unconscious forgetfulness of unpleasant and conflict producing emotions.

**Rationalization:** It is a defence mechanism in which an individual justifies his failures and socially unacceptable behavior by giving socially approved reasons.

For example, a student who fails in the examination may complain that the hostel atmosphere is not favorable and has resulted in his failure to get through.

**Intellectualization:** Focusing of attention on technical or logical aspects of a threatening situation.

For example, a wife describes the details of the nurse's unsuccessful attempts to prevent the death of her husband.

**Compensation:** Attempting to overcome feelings of inferiority or make up for a deficiency.

For example, a student who fails in his studies may compensate by becoming the college champion in athletics.

**Substitution:** A mechanism in which original goals are substituted by others.

For example, a student who has not been accepted for admission in a medical college may satisfy herself by becoming a nurse.

**Sublimation:** Unconscious gradual channelization of unacceptable impulses into personally satisfying and socially valuable behavioral pattern.

For example, a hostile young man who enjoys fighting becomes a football player.

**Suppression:** Suppression is an intentional pushing away from awareness of certain unwelcome ideas, memories or feelings.

For example, a student consciously decides not to think about her weekend so that she can study effectively.

**Reaction formation:** Unconscious transformation of unacceptable impulses into exactly opposite attitudes, impulses, feelings or behaviors, i.e. unacceptable real feelings are repressed and acceptable opposite feelings are expressed.

For example, a young man with homosexual feelings, which he finds to be threatening, engages in excessive heterosexual activities.

**Displacement:** Unconscious shifting of emotions usually aroused by perceived threat from an unconscious impulse, to a less threatening external object which is then felt to be the source of threat.

For example, a person who is angry with his boss, but cannot show it for fear of losing the job may fight with his wife and children on return from the office.

**Denial:** Refusal to accept or believe in the existence of something that is very unpleasant.

For example, an addict takes alcohol everyday and he cannot think of a day without it. However he says "I am not an addict, if I decide I can give up."

**Isolation:** Separation of the idea of an unconscious impulse from its appropriate affect, thus allowing only the idea and not the associated affect to enter awareness, as in the ability to express traumatic experiences without the associated disturbing emotions, with passage of time.

For example, a soldier humorously describes how he was seriously wounded in the war.

**Projection:** Unconscious attribution of one's own attitudes and urges to other persons, because of intolerance or painful affect aroused by those attitudes and urges. A person who blames another for his own mistakes is using the projection mechanism.

For example, a surgeon whose patient does not respond as well as he anticipated may tend to blame the theater nurse who helped the doctor at the time of operation.

**Regression:** Coping with present conflict or stress by returning to earlier, more secure stage of life.

For example, tears, temper tantrums in adults are very effective in overcoming stress.

**Conversion:** A mental mechanism in which an emotional conflict is expressed as a physical symptom for which there is no demonstratable organic basis.

For example, a student very anxious about his exams may develop a headache.

**Undoing:** Unconsciously motivated acts, which magically or symbolically counteract unacceptable thoughts, impulses or acts.

For example, a mother who has just lost her temper and beaten her children develops compulsive handwashing and child checking behaviors.

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