Psychiatric/ Mental Health Nursing

إعداد المادة العلمية

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SecondYear

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Course Specification Technical Nursing Institute

Psychiatric/Mental Health Nursing

Basic Information:

4th level (2nd year)	Psychiatric/Mental Health Nursing	
Distribution of the Course: one term Theory :13 weeks x 2 = 26 + 2 weeks for revision (4 hrs) = 30 hours Clinical practices :13 weeks X8 hours = 104 hours + 2 weeks for revision and clinical exam (16 hrs) = 120 hours Total: 15 X10 hours= 150 hours		

PROFESSIONAL INFORMATION:

The focus of the psychiatric mental health nursing course will be on developing student's interactive skills, problem solving, and critical thinking skills through psychiatric nursing intervention.

Course aim:

This course aims at empowering the technical nursing institute students, in communication, intellectual, and practical skills that allow them to implement preventive, curative, & rehabilitative psychological intervention to patients with psychiatric disorders**.**

Competencies:

1. Promotion effective communication strategies
2. Differentiation between characteristics of mental health and mental illness.
3. Using knowledge and ability to recognize psychotic signs and symptoms of changes in mental health
4. Demonstration of knowledge and ability to provide health teaching and caring related to medication administration
5. Demonstrate knowledge and ability to maintain confidentiality with client, colleagues, staff, team and organization
6. Uses teaching plan based on knowledge and learning principles for individual and groups experiences of mental illness

7. Exhibition of knowledge and ability to perform comprehensive mental health assessments of client
8. Exhibition of knowledge and ability to stress management .

Intended Learning Outcomes:

Knowledge and understanding:

A-1-Identify effective communication strategies

- interpersonal
- professional
- therapeutic

A-2- Apply verbal and non-verbal techniques to establish effective communication with inter-professional team.

- timeliness
- adjust style as necessary
- write clearly and accurately

A.3- Differentiate between characteristics of mental health and mental illness.

A.4- Identify strategies of stress management techniques

A.5- Recognize electroconvulsive therapy

A.6-Identify principles of dealing with psychiatric patient

A.7- Differentiate between defense mechanisms

A.8- Recognize aging process and psychogeriatric

A.9- Identify nursing process through plan of caring

A.10- Differentiate between different signs and symptoms of psychotic disorders

A.11-Identify signs and symptoms related to different types of addiction

B- Intellectual skills:

B-1-Interpret knowledge to apply verbal and non-verbal communication techniques to create therapeutic relationships including:

- active listening
- paraphrasing and reflecting

□□seek clarification

B-2-Use knowledge to define and maintain professional andpersonal boundaries related to:

□□ Principles of dealing with psychiatric patient

□□Understanding interpersonal relationships

B-3-Integrate knowledge to assess client functional status toindependently perform self-care including:

□□basic:

o dressing

o functional mobility/lift and transfer

o ambulation/range of motion

o personal hygiene and grooming

o feeding/hydration

o toilet hygiene

B-4-Interpret knowledge to provide evidence informed, client centered care in relation to mental health nursing:

□□engage client in plan of care

□□consider Legislation affecting mentally competent and mentally incompetentclient

□□treatment controls

B-5-Formulate knowledge and ability to differentiate between mental illness and mental wellness.

B-6-identify thementa health illness including:

□□Alzheimer's disease/dementia

□□psychosis

□□schizophrenia

B-8-Exhibit knowledge to perform comprehensive mental health assessments of client.

B-9-Use knowledge to recognize psychotic signs and symptoms of changes in mental health including:

□□behavioral

□□emotional

□□intellectual

□□level of alertness

□□motor

□□perception of reality

□□suicidal ideation

B.10- Synthesize data assessment to formulate psychiatric mental health nursing diagnosis

B.11- Integrate skills of psychiatric mental health nursing in the application of nursing plan to assist the client experience mental illness.

B.12 Formulates the skills that are needed to provide psychiatric mental health nursing care for psychiatric patients.

B.13 Uses teaching/learning principles in implementing educational activities to patient/client and his families regarding mental health

C- Professional skills:

C-1-Use communication techniques to address barriers including:

□□cognitive

□□cultural

□□developmental

□□emotional

□□functional

□□mental

□□social

□□spiritual

C-2-Participate knowledge and ability to implement or assist with psychosocial interventions in consultation with authorized professional(s) including:

□□art and music therapy

□□behavior modification

□□cognitive therapy

□□drug recovery educational programs

□□family therapy

□□motivational therapy

□□occupational therapy

□□positive and negative reinforcement

□□psychoanalysis

□□psychotherapy

C-3-Use knowledge to assist with provision and care of electroconvulsive (ECT) therapy:

□□pre and post procedural assessments and care

□□intra-procedural assessment, monitoring and care

□□ongoing client observation

C.4- Demonstrate effective therapeutic communication during interacting with psychiatric patients.

C.5- Apply psychiatric mental health intervention for mentally ill patients according to their disorders.

C.8- Conduct appropriate nursing care skillfully and in accordance with evidence based practices for Psychotropic Drugs.

C.7 Conduct effective professional working relationship with mental health team

D- Transferable skills:

D-1- Use appropriate communication techniques to establish, maintain and close the therapeutic nurse-client relationship related to:

□□health teaching and coaching

□□supportive measures and intent

□□trust and respect

D-2-Demonstrate knowledge to consider safety of self and others when managing aggressive behavior.

D-3-Demonstrate knowledge to consider safety of self and others when managing aggressive behavior.

D-5-Demonstrate knowledge to provide health teaching and coaching related to care of psychotropic medications

D-6- Demonstrate knowledge and ability to communicate and collaborate with inter-professional team.

D-7-Demonstrate knowledge to perform additional client assessment prior to the "rights" and "checks" of medication administration according to agency policy monitoring and evaluation of medication effectiveness.

D-8-Demonstrate knowledge to maintain confidentiality with client, colleagues, staff, team and organization including:

- adhere to policy, procedures, guidelines, standards, Legislation
- identify breaches in confidentiality
- manage all client information appropriately (verbal, written, electronic)
- recognize and manage risks

D.9 Uses teaching plan based on knowledge and learning principles for individual and groups experiences of mental illness.

D.10 Use communication skills effectively in inter-professional, social or therapeutic context with the patients, health team and colleagues;

D.11 Participate in ongoing educational activities related to professional issues

D.14-Adopt teaching plan based on knowledge of teaching and learning principles for individual and groups experiences mental illness.

Course content (Theory):

No	Topics		Hours
1	Introduction		2 hours
2	Mental health & Mental illness.		2 hours
3&4	Psychiatric signs& symptoms		4 hours
5	Principles of Psychiatric mental health Nursing		2 hours
6	Therapeutic Communication & Therapeutic Relationship & How to conduct Psychiatric Interview		2 hours
7	Patient's right		2 hours
8	Electroconvulsive therapy		3 hours
9	Coping & defense mechanisms		2 hours
10	Stress & Stress Management		2 hours
11	Child & Adolescents Disorders -Ageing Process		2 hours
12	Nursing care for Psychotropic Drugs		3 hours
13	Nursing care for Electroconulsivetherapy		2 hours
	Total hours		26 hours

Teaching methods

- Interactive lectures
- Case presentation
- Role play
- Presentation
- Videos

Facilities required for teaching and learning:

- Data show, Blackboard

List of references

- Essential books.
- Web sites

Student Assessment Methods:

- Assignments to assess intellectual & transferable skills.
- Records and plan, case presentation to assess professional & intellectual skills.
- Midterm exam to assess knowledge & understanding, intellectual& transferable skills.
- Final term exam to assess knowledge and understanding skills & intellectual skills.

Weighting of Assessment

ITEM	Total Mark
Clinical practice Nursing process,& case presentation	40
Communication	5
Attendance	5
Mid-Term Exam.	10
Final clinical exam	20
Final-Written Exam.	120
TOTAL	200

List of References

1- Recommended Books

2- Periodicals, Web Sites ….etc.

http:/www.psychweb.com

http://www.who.int/en/

http://www.nimh.nih.gov

http://www.psych.org/

http://www.bjp.rcpsych.org/

http://pn.psychiatryonline.org/

www.psychpage.com

Facilities Required for Teaching and Learning

1- Computer skills & internet;

2- Data show;

3- Psychiatric hospital;

4- Laboratory for applying skills.

Mental health & Mental illness.

Mental health and mental illness are difficult to define precisely. Peoplewho can carry out their roles in society and whose behavior is appropriateand adaptive are viewed as healthy. Conversely, those who fail to fulfillroles and carry out responsibilities or whose behavior is inappropriate areviewed as ill. The culture of any society strongly influences its values andbeliefs, and this in turn affects how that society defines health and illness.What one society may view as acceptable and appropriate, another societymay see as maladaptive and inappropriate.

Health

The World Health Organization defines health as a state of complete physical,mental, and social wellness, not merely the absence of disease or infirmity.

CONCEPT OF MENTAL HEALTH

People in the helping professions seem to agree that mental health is a positive state in which one is responsible, displays self-awareness, is self-directive, is reasonably worry free, and can cope with usual daily tensions. Such individuals function well in society, are accepted within a group, and are generally satisfied with their lives. Other definitions refer to the ability to solve problems; fulfill one's capacity for love and work; cope with crises without assistance beyond the support of family or friends; and maintain a state of well-being by enjoying life, setting goals and realistic limits, and becoming independent, interdependent, or dependent as the need arises without permanently losing one's independence.

Cultural beliefs influence how mental health and mental illness are determined. For instance, acceptable behavior in one cultural group may or may not be tolerated in another group.

Mental health has many components, and a wide varietyof factors influence it.

Individual,Or personal, factors include

- A person's biologicmakeup
- Autonomy and independence
- Self-esteem
- Capacityfor growth
- Vitality
- Ability to find meaning in life

- Emotionalresilience or hardiness
- Sense of belonging
- Realityorientation
- Coping or stress management abilities

Interpersonalor relationship, factors include

- Effectivecommunication,
- Ability to help others, intimacy,
- A balanceof separateness and connectedness.

Social/cultural, *or*environmental, factors include

- A sense of community,
- Access to adequate resources,
- Intolerance of violence,
- Supportof diversity among people,
- Mastery of the environment,
- A positive, yet realistic, view of one's world.

Mental Illness

The American Psychiatric Association definesa **mental disorder** as "a clinically significant behavioral orpsychological syndrome or pattern that occurs in an individualand is associated with

- Present distress (e.g., a painfulsymptom)
- Disability (i.e., impairment in one or moreimportant areas of functioning)
- Significantlyincreased risk of suffering death, pain, disability,
- loss of freedom"

General criteria todiagnose mental disorders include

- Dissatisfaction withone's characteristics, abilities, and accomplishments
- Ineffectiveor unsatisfying relationships
- Dissatisfaction withone's place in the world
- Ineffective coping with life events
- Lack of personal growth.
- The person'sbehavior must not be culturally expected or sanctioned. However,deviant behavior does not necessarily indicate amental disorder.

Factors contributing to mental illness can also be viewedwithin individual, interpersonal, and social/cultural categories.

Individual Factors

Biologic makeup,

- Intolerable
- Unrealistic worries
- Fears
- Inability to distinguish realityfrom fantasy
- Intolerance of life's uncertainties
- A sense ofdisharmony in life
- A loss of meaning in one's life

Interpersonalfactorsinclude

- Ineffective communication
- Excessivedependency on others
- Withdrawal from relationships
- Nosense of belonging
- Inadequate social support
- Loss ofemotional control.

Social/cultural factors include

- Lack ofresources,
- Violence,
- Homelessness,
- Poverty,
- An unwarrantednegative view of the world,
- Discrimination such asstigma, racism, classism, ageism, and sexism.

HISTORICAL PERSPECTIVES OF THE TREATMENT OF MENTAL ILLNESS

Ancient Times

People of ancient times believed that any sickness indicated displeasure of the Gods and, in fact, was a punishment for sins and wrongdoing. Those with mental disorders were viewed as being either divine or demonic,depending on their behavior. Individuals seen as divine were worshipped and adored; those seen as demonic were ostracized, punished, and sometimes burned at the stake.

Later, Aristotle (382–322 BC) attempted to relate mentaldisorders to physical disorders and developed his theorythat the amountsof blood, water, and yellow and blackbile in the body controlled the emotions. These four substances,or humors, corresponded with happiness, calmness,anger, and sadness. Imbalances of the four humorswere believed to cause mental disorders, so treatment wasaimed at restoring balance through bloodletting, starving

Phases Development of Psychiatric–Mental Health Nursing

Phase 1: The Emergence of Psychiatric–Mental Health Nursing (1773–1881)

• Special institutions for individuals with psychiatric disorders were built.

•**Benjamin Rush** wrote the first American textbook on psychiatry.

• Attendants were hired to socialize with patients.

•**Philippe Pinel** classified patients according to their observable behaviors.
• Schools of nursing were established in Boston and Philadelphia by 1872.
• **Dorothea Lynde Dix** devoted time to improving conditions for the mentally ill.

Phase 2: Development of the Work Role of the Psychiatric Nurse(1882–1914)
• Training schools for nurses in the psychiatric setting were established at McLean Hospital in Belmont, Massachusetts, and at Buffalo State Hospital in New York (1882).
• Trained nurses were employed in state mental hospitals (1890).
• First undergraduate psychiatric nursing program was established.
• National Society for Mental Hygiene was founded in 1909.
• Large state mental hospitals were built in rural areas.

Phase 3: Development of Undergraduate Psychiatric Nursing Education (1915–1935)
•**Linda Richards,** the first graduate nurse in the United States, suggested that mentally ill patients receive the same quality care as physically ill patients.
• Student nurses received clinical experience in state mental hospitals.
• Textbooks focusing on psychiatric nursing practice were written.
•**Harriet Bailey** wrote the first psychiatric nursing textbook, Nursing Mental Diseases.
• Insulin shock therapy, electroconvulsive therapy, and prefrontal lobotomy were introduced in the psychiatric clinical setting.
• The National Committee for Mental Hygiene was established.

Phase 4: Development of Graduate Psychiatric Nursing Education (1936–1945)
• Clinical experiences in psychiatric hospitals were standardized by 1937.
• Approximately half of all nursing schools provided psychiatric nursing courses; however, participation in psychiatric courses did not become a requirement for nursing licensure until 1955.
• The National League of Nursing Education developed curriculum guidelines for psychiatric nursing graduate education. By 1943, three university-sponsored graduate programs existed.

Phase 5: Development of Consultation and Research in Psychiatric Nursing Practice (1946–1956)
• The Mental Health Act of 1946 provided funding of graduate nursing programs to prepare psychiatric clinical nurses.
• The National League of Nursing Education formed a committee in 1956 to review and revise a proposed guide for the development of an advanced clinical course in psychiatric nursing. The Brown Report, a product of the committee's meeting, stressed that interest in the field of psychiatry should be stimulated to facilitate research focusing on the prevention and cure of mental illness.

The following is a chronologic listing of some important events influencing psychiatric nursing:

1856–1929	Emil Kraepelin differentiated manic-depressive psychosis from schizophrenia and stated that schizophrenia was incurable.
1856–1939	Sigmund Freud introduced psychoanalytic theory and therapy. He explained human behavior in psychological terms and proved that behavior can be changed in certain situations.
1857–1939	Eugene Bleuler described the psychotic disorder of schizophrenia (formerly referred to as dementia "praecox").
1870–1937	Alfred Adler focused on the area of psychosomatic medicine, referring to organ inferiority as the causative factor.
1875–1961	Carl Jung described the human psyche as consisting of a social mask (persona), hidden personal characteristics (shadow), feminine identification in men (anima), masculine identification in women (animus), and the innermost center of the personality (self).
1940–1945	World War II veterans received financial support and vocational rehabilitation for psychiatric and physical disabilities.
1946–1971	Care of mentally ill persons was brought into the mainstream of health care. World Federation for Mental Health provided funds for research and education.
1947	Helen Render wrote Nurse–Patient Relationships in Psychiatry.
1949	The National Institute of Mental Health was established to (1) provide grants-in-aid, (2) fund training programs and demonstration projects, and (3) provide support for research.
1952	Hildegard E. Peplau wrote Interpersonal Relations in Nursing, a text that provided the basis for the development of therapeutic roles in nurse–client relationships. This book was of paramount importance in the development of psychiatric nursing as a profession.
1955	The Joint Commission on Mental Illness and Health was developed to study and evaluate needs and resources.
1961	The World Psychiatric Association examined the social consequences of mental illness.

SIGNS & SYMPTOMS OF PSYCHIATRIC ILLNESS

Composition of mind

- Intellect: it includes consciousness, memory, orientation, perception, attention and concentration, thought process, insight, knowledge judgment, and intelligence.
- Emotion: it is the inner feeling of experiences of the individual.
- Behavior: is the conduct of the individual

I- Consciousness

A state of awareness

A. Disturbances of consciousness

Are most often associated with brain pathology.

- **Disorientation:** Disturbance of orientation in time, place and person.
- **Stupor:** Lack of reaction to and unawareness of surroundings.
- **Delirium:** restless, confused, disoriented reaction associated with fear and hallucinations.

II- Emotion

A. Affect:

Observed expression of emotion; may be inconsistent with patient's description of emotion.

- **Appropriate affect:** condition in which the emotional tone is in harmony with the accompanying idea, thought, or speech.

B. Mood:

- **Dysphonic mood:** an unpleasant mood.
- **Irritable mood:** easily annoyed
- **Labile mood (swings):** between euphoria and depression or anxiety.
- **Elevated mood:** a mood more cheerful than usual.
- **Euphoria:** intense elation with feelings of grandeur.
- **Depression:** psychopathological feeling of sadness.

C. Physiological disturbances associated with mood:

Signs of somatic (usually autonomic) by dysfunction of the person, most often associated with depression.

- **Anorexia:** loss of or decrease in appetite.
- **Hyperphagia:** increase in appetite and intake of food.
- **Insomnia:** Lack of or diminished ability to sleep.

III. Motor behavior

- **Echopraxia:** pathological imitation of movements of one person by another.
- **Catatonia:** motor anomalies in nonorganic disorders. (as opposed to disturbances of consciousness and motor activity secondary to organic pathology).

Waxy flexibility (cerea flexibilities): the person can be molded into a position that is them maintained; when the examiner moves the person's limb, the limb feels as if it is made of wax.

- **Negativism:** motiveless resistance to all attempts to be moved or to all instructions.
- **Stereotypy:** repetitive fixed pattern of physical action or speech.

Psychomotor agitation: Excessive motor and cognitive over activity; usually nonproductive and in response to inner tension.

A. Compulsion: uncontrollable impulse to perform an act repetitively:

Aggression: forceful goal-directed action that may be verbal or physical; the motor counter part of the effect of rage, anger or hostility.

- IV. Thinking

A. General disturbances in form or process of thinking:

- **Psychosis:** inability to distinguish reality from fantasy; impaired reality testing, with the certainty of a new reality.
- **Reality testing:** the objective evaluation and judgment of the world outside the self..

B. Specific disturbances in the form of thought:

- **Neologism:** new word created by the patient, often by combining syllables of other words for idiosyncratic psychological reasons.
- **Word salad:** incoherent mixture of words and phrases.
- **circumstantially:** indirect speech that is delayed in reaching the point but eventually gets from original point to desired goal; characterized by an over inclusion of details.
- **Incoherence:**though, that generally is not understandable; running together of thoughts or words with no logical or grammatical connection, resulting in disorganization.
- **Perseveration:** persisting response to a prior stimulus after a new stimulus has been presented often associated with cognitive disorders.
- **Verbigeration:** meaningless repetition of specific words or phrases.
- **Echolalia:** psychopathological repeating of words or phrases of one person by another; tends to be repetitive and persistent.
- **Flight of ideas:** rapid, continuous verbalizations or plays on words producing constant shifting from one idea to another; the ideas tend to be connected, and in the less severe form a listener may be able to follow them.
- **Clang association:** association of words similar in sound but not in meaning; words have no logical connection may include rhyming and punning.
- **Blocking:** abrupt interruption in train of thinking before a thought or idea is finished; after a brief pause; the person indicates no recall of what was being said or was going to be said.

C. Specific disturbances in content of thought:

- **Overvalued ideas:** unreasonable, sustained false belief maintained less firmly than a delusion.
- **Delusion:** false belief, based on incorrect inference about external reality, not consistent with patient's intelligence and cultural background that cannot be corrected by reasoning.

A. ***Nihilistic delusion***: false feeling that the self, others, or the world is nonexistent

or ending.

B. ***Delusion of poverty:*** false belief that one is deprived or will be deprived of all material possessions.

C. ***Somatic delusion:*** false belief involving functioning of one's body ex., belief that one's brain is rotting or melting.

D. ***Paranoid delusions:*** include persecutory delusions and delusions of reference, control and grandeur (distinguished from paranoid ideation, which is suspiciousness of less than delusional proportions) it includes:

- Delusion of persecution:

False belief that one is being harassed, cheated, or persecuted often found in litigious patients who ha a pathological tendency to take legal action because of imagined mistreatment.

- Delusion of grandeur:

Exaggerated conception of one's importance, power, or identity.

- Delusion of reference:

False belief that the behavior of others refers to one self; that events, objects, or other people have a particular and unusual significance usually of a negative nature; derived from idea of reference in which one falsely feels that one is being talked about by others.

ex., belief that people on T.V or radio are talking to or about the patient.

- Delusion of control:

False feeling that one's will, thought, or feeling is being controlled by external forces it includes:

***Thought withdrawal:** Delusion that one's thoughts are being removed from one's mind by other people or forces.

***Thought insertion:** Delusion that thoughts are being implanted in one's mind by other people or forces.

*** Thought broadcasting:** Delusion that one's thoughts can be heard by others, as thought they were being broadcast into the air.

*** Hypochondria:** exaggerated concern about one's health that is based not on organic pathology but, rather, on unrealistic interpretations of physical signs or sensations as abnormal.

- **Obsession:** pathological persistence of an irresistible thought or feeling that cannot be eliminated from consciousness by logical effort, which is associated with anxiety. (Also termed rumination).
- **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.
- **Phobia:** persistent, irrational, exaggerated and in variably pathological dread of some specific type of stimulus or situation, results in a compelling desire to avoid the feared stimulus.

a. ***Specific phobia:*** dread of spiders or snakes

b. ***Social phobia:*** as in fear of public speaking, performing, or eating in public**.**

c. ***Acrophobia:*** dread of high places.

d. ***Agoraphobia:*** dread of open places.

e. ***Claustrophobia:*** dread of closed places.

V. Speech:

A. Disturbances in speech:

- **Pressure of speech:** rapid speech
- **Poverty of speech:** restriction in the amount of speech used

VI. Perception:

A. Disturbances of perception:

- **Hallucination:**

False sensory perception not associated with real external stimuli; there may or may not be a delusional interpretation of the hallucinatory experience.

a. Auditory hallucination:

False perception of sound, usually voices

b. Visual hallucination:

(ex. flashes or light)

c. Olfactory hallucination:

False perception of smell;

d. Gustatory hallucination:

False perception of taste, such as unpleasant taste

e. Tactile hallucination:

False perception of touch or surface sensation,

- **Illusion:**

Misperception or misinterpretation of real external sensory stimuli.

VII. Memory:

A. Disturbances of memory:

- **Amnesia**: Partial or total inability to recall past experiences; may be organic or emotional in origin.

a. ***Confabulation:*** unconscious filling of gaps in memory by imagined or untrue experiences that patient believes but that have no basis in fact; most often associated with organic pathology.

b. ***Déjà vu:*** illusion of visual recognition in which a new situation is incorrectly regarded as a repetition of a previous memory.

IX. Insight:

Ability of the patient to understand the true cause and meaning of a situation (such as symptoms).

X. Judgment:

Ability to assess a situation correctly and act appropriately within that situation.

Psychiatric nursing principles

Principles of Dealing with Psychiatric Patients

Learning Objectives

At the end of this lecture, each student should be able to:

Identify the principles that guide the psychiatric nurse behavior.

List Psychiatric nursing principles.

Apply psychiatric nursing principles in dealing with psychiatric patients.

principles as follow:

1. Accepting patients exactly as they are
2. Maintaining patient contact with reality
3. Seeking validation from the patient
4. Self-understanding used as a therapeutic tool
5. Consistency
6. Reassurance
7. Avoid increasing patient anxiety
8. Necessity of motor and sensory stimulation
9. Influence of expectations on patient behavior
10. Change in patient behavior through emotional experience
11. Consideration of reason for patient behavior
12. Realistic nurse patient relationship

1- Accepting patients exactly as they are

Acceptance is a series of positive behaviors designed to convey to the patient respect, worth, and dignity.

Acceptance is expressed through non-judgmental and non-punitive relationship with psychiatric patient.

Direct and indirect expressions of interest in the patient recognition and reflection of the patient's feelings.

Talking with understanding to the patient.

Listening to the patient and permitting him to express feeling.

To accept a patient, as a person does not mean we approve his behavior.

Talking provides a means of conveying acceptance to patient. The conversation should be centered on the patient on his needs and wants and on his interests.

A. In accepting patient through a non-judgmental approach we avoid all moral judgment and its expression, a patient's behavior is no right or wrong, no good or bad
B. In an accepting a non-punitive approach to the patient, it means that, the patient should not be punished directly or indirectly for his expressions as avoiding patient except when something must be done for him, calling attention to his defects,

Laughing about the patient's fears which bring more state of emotional instability and impact on his self esteem.

2-Maintaining contact with reality:

Most persons who have developed or who are susceptible to develop behavioral disorders have difficulties with their reality checking mechanisms. In fact most normal persons have some difficulties along such lines they tend to see reality as they want it to be, rather than as it is. When such problems overwhelm individual functioning and interfere markedly with social adjustment. In the care of such patient there must not be support of the patient's unrealistic idea or behavior.

3-Seeking validation from the patient:

It is the meaning of feelings and behavior from the patient's point of view.
That is of primary importance and only patient knows how experience looks to him.
Therefore the logical procedure is to seek validation from the patient to check against the nurse's interpretation of how he sees things.
Provide the patient with an opportunity to correct or to confirm the conclusion as only he can do.

The essence of the helping relationship is the ability to convey to the patient the sense of trying to understand him.

4-Self-understanding used as a therapeutic tool:

In developing need to participate effectively in the care of patients with personality disorders the nurse must know how to realistically approach.

The problem of bringing about change within herself she will become comfortable enough in her relationship with patients to be helpful only when she feels some security about her ability to respond appropriately to patient behavior.

The method of approaching this problem is important because it will probably determine how effective the nurse will eventually become.

The nurse needs to learn to accept herself as a part of learning how to accept others; she can try to identify what she actually feels and thinks as the first step in bringing about change in herself since this will identify what is to be changed.

The nurse needs to analyze her own behavior and her patient's behavior. It is often helpful to do this with someone else in the situation rather than to try to do it alone.

5-Consistency:

No standard pattern of behavior for any situation in a psychiatric setting.

The same words used by two different nurses will have two different meanings to the same patient.

The stereotyped behavior responses to types of situations are potentially dangerous.

The resulting inconsistency between feelings and actions lessens the nurse's effectiveness in a relationship.

One of the most effective measures to promote a sense of security is consistency in experience and attitude of personnel toward the patient.

Consistency between feelings & thoughts of nurse and her behavior (action) is very important for effectiveness in a relationship.

6-Reassurance:

All of us need reassurance at one time and another and psychiatric patients need it constantly.

Reassurance is a great deal more suitable, than telling the patient that he will get well, that his fears are groundless, that he is a nice person, and that all will end well.

Reassurance is building patient's confidence or restoring confidence.

Verbal reassurance is effective only when it does not contradict to the patient needs.

It can be given through awareness and acceptance of how the patient really feels.

7-Avoiding increasing patient anxiety:

As a general rule, fear and anxiety are already problems with which the patient has been unable to cope carefully.

To insist that a depressed patient cheer up or that active patient to sit down and be quiet or that withdrawn patient initiates and carries through group activities simply places the patient in the position of having failed, again failure causes anxiety.

In persons already insecure, the use of medical and psychiatricterminology in front of patient can often produce anxiety.

The nurse must be careful to avoid judgment or comments that may add to a patient's anxiety.

8-Necessity of motor and sensory stimulation:

Motor stimulation can be through encouraging and asking patient to accomplish his daily routine and needs, sensory stimulation can be through frequent application of various sensory functions as hearing, vision and touch within his environment.

9-Influence of expectations on behavior:

It has been demonstrated in a wide variety of school situations that where failure is expected a high degree of failures occur. Where the expectation is that the students can succeed a high percentage do so.

The willingness to help, the level at which help is offered and ultimately the depth of the belief in human worth and dignity. All of these factors influence the expectation of behavior on the part of others.

For the nurse this expectation is an awareness of what she expects patient behavior to be and why, the importance of seeing the potential for growth in every patient and the active seeking for his strengths and resources became important rule in therapeutic program.

10-Change in patient behavior through emotional experience:

The major focus in psychiatric therapy and in psychiatric nursing is upon the feeling aspect of the personality not upon the intellectual aspects.

It is necessary to try to see it from the inside the patient's emotional need for his beliefs.

Reason is not an effective weapon in changing patient behavior the ideal goal of therapy is to help the patient to such a degree of emotional security that he can develop and use an understanding of his behavior such understanding cannot be forced upon him from outside nor can he use his knowledge until he can emotionally accept it. The interpretation can be done only when the patient is ready or secure enough to tolerate it and able to apply it to alter his behaviors.

11-Consideration of reason for behavior:

Everything the patient says and does should be observed recorded and reported.

That information is useful for directing the patient's therapeutic program. In addition they are helpful for the nurse's information in care planning.

The patient's behavior should be analyzed to seek its motivation and to understand what the patient is attempting to accomplish.

12-Realistic nurse patient relationship:

It is essential that the relationship, the nurse offers to the patient be founded on a realistic basis. The warm and understanding professional relationship of nurse and patient can help greatly in establishing the kind of environment. Patient needs to give him an opportunity to get well, and needs the support in relationship based on the three phases which we talked about it in the lecture of therapeutic communication. A relationship that is based on mutual respect and trust will tolerate the strains and stresses of termination.

Communication Process

Definition of communication:

It is a two way complex process of sending a message (ideas, information, values, feelings or attitudes) between two or more persons.

Definition of Therapeutic communication:

A professional and planned relationship between patient and nurse that focuses on the patient's needs feelings, problems, and ideas.

Levels of Communication

- **Intrapersonal Level**
  Intrapersonal communication is the messages one sends to oneself, including self-talk, or communication with oneself.
- **Interpersonal Level**
  Interpersonal communication is the process that occurs between two people either in face-to-face encounters, over the telephone, or through other communication media.

Elements of communication process

Three elements of the process: perception, evaluation, and transmission.

Perceptionoccurs by activation of the sensory end organs of the receiver. The impulse is then transmitted to the brain. When the sensory impulse reaches the brain, ***Evaluation*** takes place.

Results in two responses:

A cognitive response related to the informational, aspect of the message, ***Affective response*** related to the relationship aspect of the message. When the evaluation of the message is complete.

Transmission takes place. This is perceived by the sender as feedback, thereby influencing the continued course of the communication cycle.

Feedback stimulates perception, evaluation, and transmission by the original sender. The cycle continues until the participants agree to end it or one participant physically leaves the setting.

Theoretical model of the communication process:

Structural Model:

The structural model has five functional components in communication.

The Sender is the originator of the message.

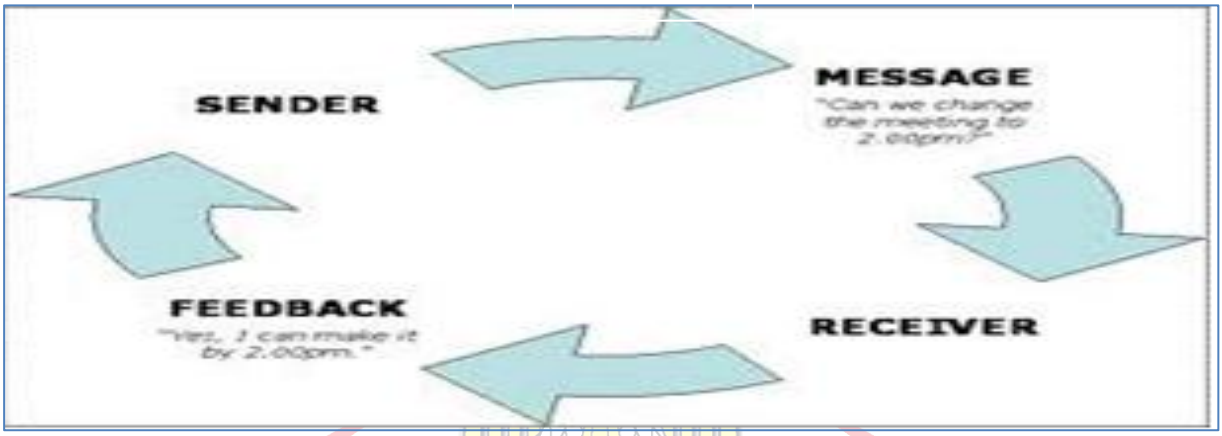
The message is the information that is transmitted from the sender to the receiver.

The receiver is the perceiver of the message.

The feedback is the verbal or behavioral response of the receiver.

The context is the setting in which the communication takes place. Knowledge of context is necessary to understand the meaning of the communication.

(Context)



Factors influencing communication

Perception

Perception is a person's sensing and understanding of the world. "Perceptions are influenced by our culture, socialization, education, and experience" They help a person determine the meaning of the words and the content of the messages being communicated.

Cultural Context

Because behavior is learned, nonverbal communication varies from culture to culture

Language

Language that describes what we want to say in our terms may present barriers to others who are not familiar with our expressions

Space and Distance

Invasion of personal space produces discomfort, anxiety.

Time

The whole communication process is influenced by time. For example, the same message received at 3:00 AM will be perceived and responded to differently at 3:00 PM.

Emotional distance

Emotional distance, involves treating the patient as a curiosity, aproblem, or a disease, thus preventing satisfying interactionand possibly causing hostility.

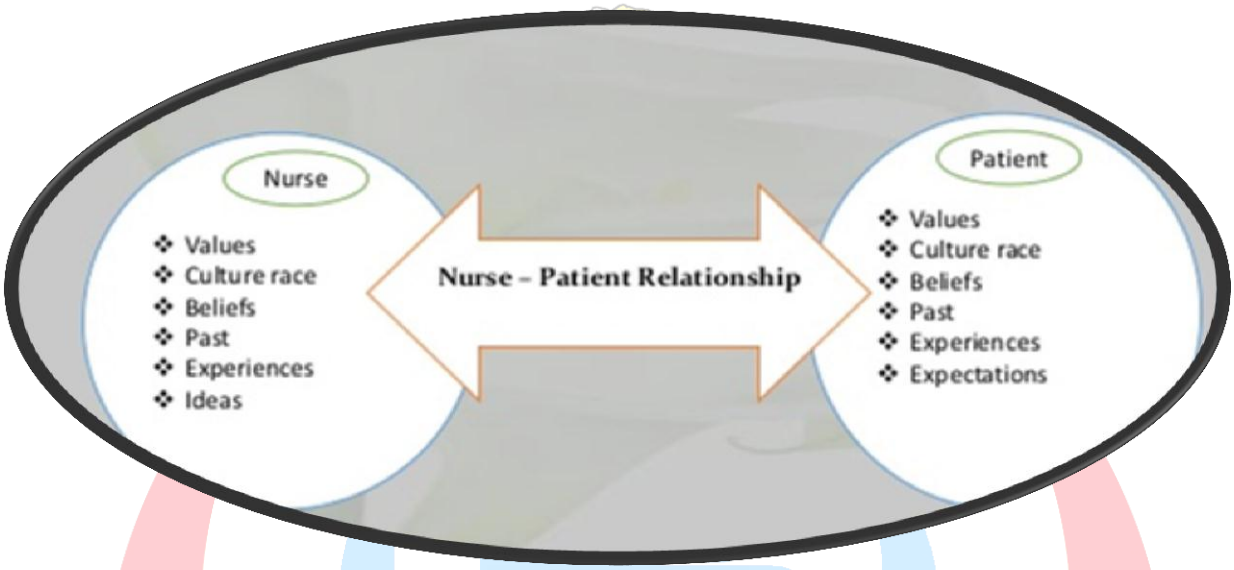
Health Status

One's health status affects communication. For example, the patient who is oriented will communicate more reliably than a patient who is delirious, confused, or disoriented.

Communication is affected by sensory perceptual alterations, such as loss of vision or hearing.

Therapeutic Relationship

Differs from the social or intimate relationship in many ways because it focuses on the needs, experiences, feelings and ideas of the patient only.



The nurse uses communication skills, personal strengths, and understanding of human behavior to interact with the patient and Focus on the patient's needs

Comparison between Social and Therapeutic Relationships

Social	Therapeutic
1. Is spontaneous, just happens. 2. Is mutually beneficial. 3. Often has no planned agenda. 4. Is based on mutual interests. 5. Each participant expects to be liked by the other. 6. Problems are shared. **7.** Communication is spontaneous	1. Is planned and goal-directed. 2. Seeks to meet patient's needs. 3. Is based on theory. 4. Privileged information is available to health care provider. 5. Patient must be accepted as is. 6. Communication is planned. **7.** Has clear-cut boundaries.

Components of a therapeutic relationship:

Trust

Trust builds when the patient believes that the nurse will be:

- Consistent in his or her words and actions.
- Being caring, interested, understanding.
- Keeping promises.
- Listeningeffectively.
- Being honest with the patient.

Genuine Interest

Genuine interest happened when:

- The nurse is comfortable with himself or herself.
- Aware of his or her strengths and limitations.
- Clearly focused.
- Thepatient perceives a genuine person showing *genuine interest.*

Empathy

Empathy is the ability of the nurse to perceive the meanings and feelings of the patient and to communicate that understanding to the patient.

Several therapeutic communication techniques, Such as:

- Reflection.
- Restatement.
- Clarification.

Acceptance

Acceptance does not mean acceptance of inappropriate behavior but acceptance of the person as worthy.

- The nurse must set boundaries for behavior in the nurse-patient relationship.
- Being clear and firm without anger or judgment

Unconditional Positive Regard

Respect the patient regardless of his or her behavior, background, or lifestyle and:

- Calling the patient by name.
- Spending time with the patient.
- Listening and responding openly are measures by which the nurse conveys respect and positive regard to the patient.
- Considering the patient's ideas and preferences when planning care.

Self-Awareness

Self-awareness is the process of developing an understanding of one'sown:

- Values.
- Beliefs.
- Thoughts.

- Feelings.
- Attitudes.
- Motivations.
- Prejudices.
- Strengths.
- Limitations
- And how these qualities affect others.

Self-awareness allows the nurse to observe, pay attention to, and understand the suitable responses and reactions of patients when interacting with them.

Therapeutic Use of Self

By developing self-awareness and beginning to understand his or her attitudes, the nurse can begin to use aspects of his or her personality, experiences, values, feelings, intelligence, needs, coping skills, and perceptions to establish relationships with patients.

Nurses use themselves as a therapeutic tool to establish therapeutic relationships with patients and to help patients grow, change, and heal.

One tool that is useful in learning more about oneself is

► ***TheJoharri window,*** which creates four areas and indicates how well that person knows himself or herself and communicates with others.

1: *Open/public self*:
Qualities one knows about oneself and others also know.
2: *Blind/unaware self*:
Qualities known only to others.
3*: Hidden/private self*:
Qualities known only to oneself.
4: *Unknown- an empty quadrant* undiscovered by oneself or others.

The goal is to work toward moving qualities from quadrants (2, 3, and 4) into quadrant (1) doing so indicates that the nurse is gaining self-knowledge and awareness.

Therapeutic Communication Techniques

Communication blocks

Certain responses that would be acceptable during social conversation are not useful during therapeutic interaction. Unhelpful techniques are those that halt the progress of the interview and may result in the patient's experiencing feelings of inadequacy, intimidation, or confusion.

Communicating with Vulnerable Populations

Confused patients	▪ Keep background noises to a minimum. ▪ Use simple, concrete words and sentences. ▪ Use pictures and symbols. ▪ Use closed rather than open-ended questions. ▪ Give the patient time to respond.
Angry patients	▪ Use caution when communicating with a patient who has a history of violent behavior or poor impulse control. ▪ Do not turn your back on the patient. ▪ Arrange the setting so that the patient is not between you and the door to the room. ▪ Focus on the patient's body language. ▪ Be alert for physical indicators of impending aggression: narrowed eyes, clenched jaw, clenched fist, or a loud tone of voice. ▪ Don't use touch.

FourPhases of the therapeutic nurse-patient relationship:

Identified four sequential phases in the interpersonal relationship:

1. Orientation
2. Identification
3. Exploitation
4. Resolution

1. Orientation Phase

The orientation phase is directed by the nurse and involves engaging the patient in treatment, providing explanations and information, and answering questions.

- Problem defining phase
- Starts when patient meets nurse as a stranger
- Defining problem and deciding type of service needed
- Patient seeks assistance ,conveys needs ,asks questions, shares preconceptions and expectations of past experiences
- Nurse responds, explains roles to patient, helps to identify problems and to use available resources and services

❖ During the orientation phase, the nurse begins to build trust with the patient.

❖ It is the nurse's responsibility to establish a therapeutic environment that fosters trust and understanding.

❖ *At the first meeting*, the nurse should share appropriate information about himself or herself at this time, including name, reason for being on the unit. The patient may be distrustful if previous relationships with nurses

have been unsatisfactory. The patient may use rambling speech, act out, or avoid discussing the real problems. It may take several sessions until the patient believes that he or she can trust the nurse.

- ❖ Nurse Patient Contracts: nurse must outline the responsibilities of the nurse and patient. In an informal or verbal contract.

  The contract should state the following:

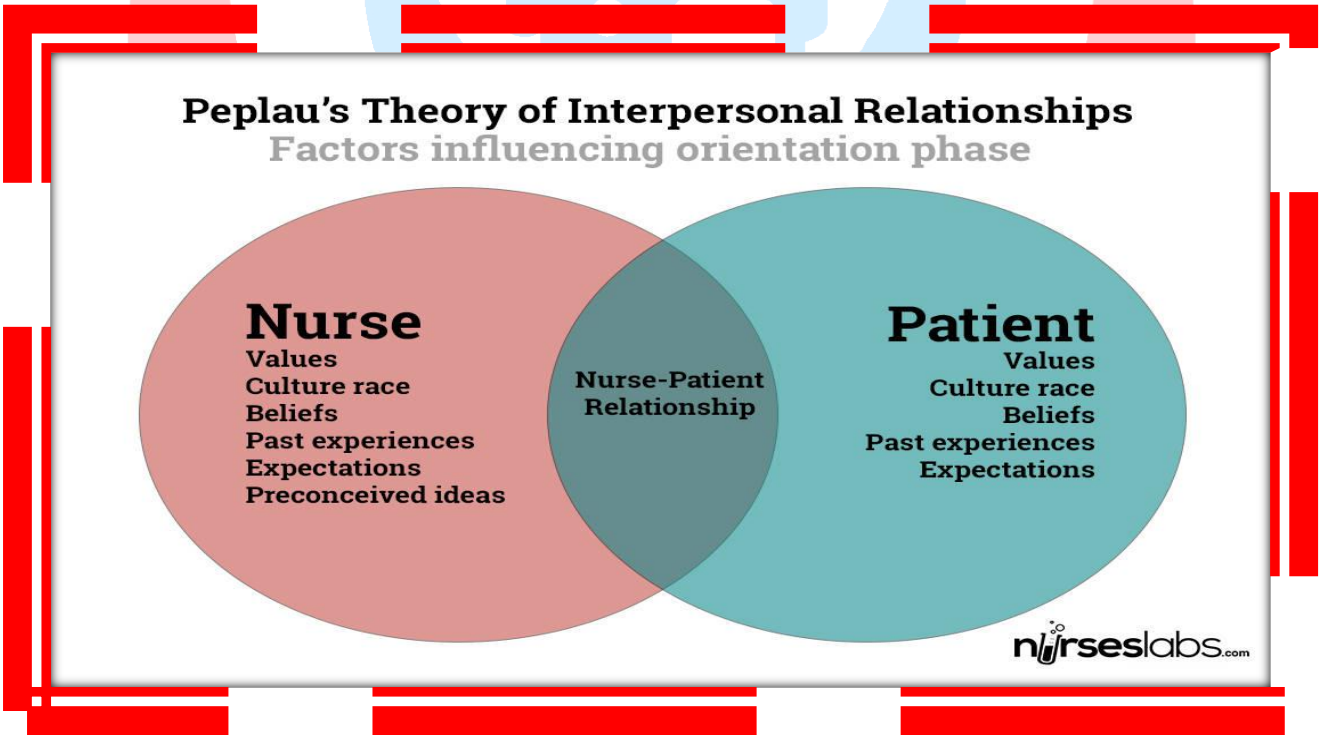
  - Time, place, and length of sessions.
  - When sessions will terminate
  - Who will be involved in the treatment plan (family members, health team members)
  - Patient responsibilities (arrive on time, end on time)

- Nurse's responsibilities (arrive on time, end on time, maintain confidentiality at all time, evaluate progress with patient, document sessions)

- Confidentiality: means respecting the patient's right to keep private any information about his or her mental and physical health and related care.

- Self-disclosure: means revealing personal information such as biographical information and personal ideas, thoughts, and feelings about oneself to patients.

➢ Nurses should remember these therapeutic goals of self-disclosure and use disclosure to help the patient feel more comfortable and more willing to share thoughts and feelings.



2. Identification Phase

The identification phase begins when the patient works interdependently with the nurse, expresses feelings, and begins to feel stronger.

- The trust established between nurse and patient at this point allows them to examine the problems and to work on them within the security of the relationship.
- Selection of appropriate professional assistance
- Patient begins to have a feeling of belonging and a capability of dealing with the problem which decreases the feeling of helplessness and hopelessness.

The specific tasks of the working phase include the following:

- Maintaining the relationship.
- Gathering more data.
- Exploring perceptions of reality.
- Developing positive coping mechanisms.
- Promoting a positive self-concept.
- Encouraging verbalization of feelings.
- Facilitating behavior change.
- Working through resistance.
- Evaluating progress and redefining goals as appropriate.
- Providing opportunities for the patient to practice new behaviors.
- Promoting independence.

As the nurse and patient work together, it is common for the patient unconsciously to transfer to the nurse feelings he or she has for significant others. This is called ***transference.***

A similar process can occur when the nurse responds to the patient based on personal unconscious needs and conflicts; this is called ***counter- transference.***

Self-awareness is important so that the nurse can identify when transference and counter transference might occur. By being aware of such "hot spots," the nurse has a better chance of responding appropriately rather than letting old unresolved conflicts interfere with the relationship.

Resistance

Resistance may be a reaction by the patient to the nurse who hasmoved too rapidly or too deeply into the patient's feelings or who has intentionally or unintentionally communicated a lack of respect. It may also simply be the result of a patient who is working with nurse who is an inappropriate role model for therapeutic behavior.

3. Exploitation Phase

In the exploitation phase, the patient makes full use of the services offered.

- In the exploitation phase, the patient makes full use of the services offered.
- Use of professional assistance for problem solving alternatives
- Advantages of services are used is based on the needs and interests of the patients
- Individual feels as an integral part of the helping environment
- They may make minor requests or attention getting techniques
- The principles of interview techniques must be used in order to explore, understand and adequately deal with the underlying problem
- Patient may fluctuates on independence
- Nurse must be aware about the various phases of communication
- Nurse aids the patient in exploiting all avenues of help and progress is made towards the final step

4. Resolution Phase

In the resolution phase, the patient no longer needs professional services and gives up dependent behavior. The relationship ends.

- Termination begins the first day of the relationship, when the nurse explains that this relationship is time limited and was established to resolve the patient's problems and help him or her handle them.
- In the resolution phase, the patient no longer needs professional services and gives up dependent behavior. The relationship ends.
- Termination of professional relationship
- The patients' needs have already been met by the collaborative effect of patient and nurse
- Now they need to terminate their therapeutic relationship and dissolve the links between them.
- Sometimes may be difficult for both as psychological dependence persists
- Patient drifts away and breaks bond with nurse and healthier emotional balance is demonstrated and both becomes mature individuals

How to conduct psychiatric interview

Introduction:

Conduct the interview for assessment is the first step of the nursing process and involves the collection, organization, and analysis of information about the patient's health. In psychiatric mental health nursing, this process is often referred to as a psychosocial assessment. The purpose of the psychosocial assessment is to construct a picture of the patient's current emotional state, mental capacity, and behavioral function. This assessment serves as the basis for developing a plan of care to meet the patient's needs. The assessment is also a clinical baseline used to evaluate the effectiveness of treatment and interventions or a measure of the patient's progress.

Environment for conduct an interview:

The nurse should conduct the psychosocial assessment in an environment that is:

- Comfortable, private, and safe for both the patient and the nurse.

- Fairly quiet with few distractions allows the patient to give his or her full attention to the interview.

The nurse should not choose an isolated location for the interview, however, particularly if the patient is unknown to the nurse or has a history of any threatening behavior. The nurse must ensure the safety of self and patient even if that means another person is present during the assessment.

Input From Family and Friends

If family members, friends, or caregivers have accompanied the patient, the nurse should obtain their perceptions of the patient's behavior and emotional state .How this is done depends on the situation. Sometimes the patient does not give permission for the nurse to conduct separate interviews with family members. The nurse should then be aware that friends or family may not feel comfortable talking about the patient in his or her presence and may provide limited information.

Or the patient may not feel comfortable participating in the assessment without family or friends. This, too, may limit the amount or type of information the nurse obtains. It is desirable to conduct at least part of the assessment without others especially in cases of suspected abuse or intimidation. The nurse should make every effort to assess the patient in privacy in cases of suspected abuse.

How to Phrase Questions

The nurse may use open-ended questions to start the assessment. Doing so allows the patient to begin as he or she feels comfortable and also gives the nurse an idea about the patient's perception of his or her situation. Examples of open-ended questions are as follows:

- **What brings you here today?**
- **Tell me what has been happeni**ng to you.
- **How can we help you?**

If the patient cannot organize his or her thoughts or has difficulty answering open-ended questions, the nurse may need to use more direct questions to obtain information. Questions need to be clear, simple, and focused on one specific behavior or symptom; they should not cause the patient to remember several things at once. Questions regarding several different behaviors or symptoms—"How are your eating and sleeping habits, and have you been taking any over the- counter medications that affect your eating and sleeping?"—can be confusing to the patient.

The following are examples of focused or closed endedquestions:

• How many hours did you sleep last night?

• Have you been thinking about suicide?

• How much alcohol have you been drinking?

• How well have you been sleeping?

• How many meals a day do you eat?

• What over-the-counter medications are you taking?

Attentive listening:

SOLER. :Several nonverbal behaviors have been designated as facilitative skills for attentive listening. Those listed here can be identified by the acronym

S	**Sit squarely facing the patient.**
O	**Observe an open posture**
L	**Lean forward toward the patient**
E	**Establish eye contact**
R	**Relax.**

CONTENT OF THE ASSESSMENT

The information gathered in a psychosocial assessment can be organized in many different ways. Most assessment tools or conceptual frameworks contain similar categories with some variety in arrangement or order. The nurse should use some kind of organizing framework so that he or she can assess the patient in a thorough and systematic way that lends itself to analysis and serves as a basis for the patient's care.

Assessment components

- History
- General appearance and motor behavior
- Mood and affect
- Thought process and content
- Sensorium and intellectual processes
- Judgment and insight
- Self-concept
- Roles and relationships
- Physiologic and self-care concerns

Interpersonal Theory and Nursing Process

Roles of a Nurse:

Peplau describes the six nursing roles that lead into the different phases:

Peplau's Six Nursing Roles:

- ***Stranger role:***

  - Peplau states that when the nurse and patient first meet, they are considered to be strangers to one another. Therefore, the patient should be treated with much respect, courtesy and equally as anybody else. The nurse should not prejudge the patient or give assumptions on the patient but take the patient as they are. The nurse should treat the patient as emotionally stable, unless evidence states otherwise.

- ***Resource role:***

  - The nurse provides answers to questions primarily on health information. The resource person is also in charge of relaying information to the patient about the treatment and plan of care. Usually the questions are arisen from larger problems therefore, the nurse would determine what type of response is appropriate for constructive learning whether giving straightforward answers or providing information on counseling.

- ***Teaching role:***

  The teaching role is a role that is a combination of all roles. Peplau determined that there are two categories that the teaching role consists of: Instructional and experimental. The instructional consists of giving a wide variety of information that is given to the patients and experimental is using the experience of the learner as a starting point to later form products of learning which the patient makes about their experiences.

- ***Counseling role:***

  Peplau believes that counseling has the biggest emphasis in psychiatric nursing. The counselor role helps the patient understand and remember what is going on and what is happening to them in current life situations. Also, to provide guidance and encouragement to make changes.

- ***Surrogate role:***

  The patient is responsible for putting the nurse in the surrogate role. The nurse's behaviors and attitudes create a feeling tone for the patient that trigger feelings that were generated in a previous relationship. The nurse helps the patient recognize the similarities and differences between the nurse and the past relationship.

- ***Leadership role:***

  Helps the patient assume maximum responsibility for meeting treatment goals in a mutually satisfying way. The nurse helps the patient meet these goals through cooperation and active participation with the nurse.

In other words :

The primary role of a nurse is to **advocate** and care for individuals of all ethnic origins and religious backgrounds and support them through health and illness. However, there are various other responsibilities of a nurse that form a part of the role of a nurse, including to:

- Record medical history and symptoms.
- Collaborate with team to plan for patient care.
- Advocate for health and wellbeing of patient.
- Monitor patient health and record signs.
- Administer medications and treatments.
- Operate medical equipment.
- Perform diagnostic tests.
- Educate patients about management of illnesses.
- Provide support and advice to patients.

➢ **Patient Care**

A nurse is a caregiver for patients and helps to manage physical needs, prevent illness, and treat health conditions. To do this, they need to observe and monitor the patient, recording any relevant information to aid in treatment decision-making.

Throughout the treatment process, the nurse follows the progress of the patient and acts accordingly with the patient's best interests in mind. The care provided by a nurse extends beyond the administration of medications and other therapies. They are responsible for the holistic care of patients, which encompasses the psychosocial, developmental, cultural, and spiritual needs of the individual.

➢ **Patient Advocacy**

The patient is the first priority of the nurse. The role of the nurse is to advocate for the best interests of the patient and to maintain the patient's dignity throughout treatment and care. This may include making suggestions in the treatment plan of patients, in collaboration with other health professionals.

This is particularly important because patients who are unwell are often unable to comprehend medical situations and act as they usually would. It is the role of the nurse to support the patient and represent the patients best interests at all times, especially when treatment decisions are being made.

➢ **Planning of Care**

A nurse is directly involved in the decision-making process for the treatment of patients. It is important that they are able to think critically when assessing patient signs and identifying potential problems so that they can make the appropriate recommendations and actions.

As other health professionals, such as doctors or specialists, are usually in charge of making the final treatment decisions, nurses should be able to communicate information regarding patient health effectively. Nurses are the most familiar with the individual patient situation as they monitor their signs and symptoms on an ongoing basis and should collaborate with other members of the medical team to promote the best patient health outcomes.

- **Patient Education and Support**

Nurses are also responsible for ensuring that patients are able to understand their health, illnesses, medications, and treatments to the best of their ability. This is of essence when patients are discharged from hospital and will need to take control of their own treatments.

A nurse should take the time to explain to the patient and their family or caregiver what to do and what to expect when they leave the hospital or medical clinic. They should also make sure that the patient feels supported and knows where to seek additional information, if needed, is crucial.

ž Mental health law

ž Introduction

ž Mental health nurses on a day-to-day basis have to make practice decisions that must be consistent with a number of legal frameworks.

ž The added dimension in mental health nursing is that these decisions may relate to either restricting a mental health service user's freedoms or, where these restrictions are in place, maintaining the use of these restrictions. This does not mean that a mental health user does not have rights – it is quite the opposite – and on this basis it is important that the mental health nurse knows how to balance autonomy against managing risk.

ž Competencies

ž Mental health nurses are required to:

ž •• Understand and apply current legislation in a way that protects

ž vulnerable individuals within their practice.

ž •• Act within the law when collaboratively working with individuals

ž living with mental health problems.

ž •• Respect and uphold a mental health service user's rights in

ž accordance with the law and relevant ethical and regulatory frameworks

ž including taking into account local protocols.

ž •• Know when to actively share personal information with others when the interests of safety and protection override the need for confidentiality.

ž The context

ž There are a number of legal frameworks that mental health nursesneed to understand and work within. Not all of these frameworksare specific to mental health care (e.g. the Human Rights Act); nonetheless the mental health nurse must still be able to work with andunderstand these frameworks. In relation to what is called mental health law, such as the Mental Health Act 1983 for England and Wales, the mental health nurse will work within a framework that allows them in certain circumstance to restrict freedoms. They will also work with legal frameworks that support individuals with severe mental problems to make decisions

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ž **The Human Rights Act**

ž The Human Rights Act 1998 came into full force in the UK in

ž 2000. The Act protects the rights of the individual through a

ž number of Articles. All these Articles are relevant to individual

ž individuals with mental health problems but where an individual's freedoms are restricted the following Articles have particular relevance:

ž •• the right to life (Article 2);

ž •• the prohibition of torture (Article 3);

ž •• the right to liberty and security (Article 5);

ž •• the right to respect for private and family life (Article 8).

ž The Mental Capacity Act

ž Generally individuals are presumed to have the capacity to make their own decisions, such as:
ž •• understand information relevant to the decision
ž •• retain, use and weigh that information in the process of making
ž that decision
ž •• communicate that decision.
ž Where individuals lack capacity there is a supportive and transparent
ž process enshrined within the Mental Capacity Act 2005.
ž This process acknowledges that a lack of capacity may be temporary and transient and that individuals lacking capacity should where possible be helped to make their decisions .

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ž **<u>Ego Defense mechanisms</u>**

ž **Introduction**

ž Change is the low of nature, every moment, change occurs in our life, one has to accommodate and adjust themselves for all those changes or stimuli in order to have peaceful life.

ž Defense mechanisms called ego defense mechanisms or mental mechanisms or coping mechanisms.

ž If the person achieves the goal by satisfying his needs he will have calm and peaceful life.

ž If any hurdles or obstacles occur in his activities which lead in delay or not achieving the goal, it results in emotional distress.

ž **Definitions**

ž The protective device or the mental capacities used by the individual against psychological dangers in order to maintain inner harmony and the efforts made by the individual to reach the goal or said objective.

ž The various automatic, involuntary and unconsciously instituted psychological activities by which the unacceptable urges or impulses are excluded from conscious awareness.

ž **Ego**

ž Is trying to maintain balance between ID and super ego by fulfilling its intermediary task by protecting Id from the dangers of the external world.

ž **Characteristics of defense mechanisms**

1- Defense mechanisms are healthy only when:

- In frequent use.
- Protect self esteem against psychological dangers.
- Forms acceptable behavior.
- Able to change the external environment.
- Modifies and reaches felt needs.

2- Defense mechanisms are unhealthy when:

- Unable to modify abnormal behavior.
- Away from reality.
- If it interferes with maintenance of self-image.
- Develop inferiority feelings, insecurity and lacks self-confidence.

3- Used by almost all individuals in the process of adjustment, exhibited in the everyday behavior of normal people.

4- Defense mechanism will be used in all level of mind either consciously or unconsciously but usually acts at the unconscious or subconscious level to compromise solutions.

5- The individual will feel secure when adjustment is in use.

6- Maintains balance and molds the personality of an individual.

ž **Purposes**

1- They protect the individual against psychological threats related to ego.

2- Reduce the distress and anxiety caused by frustration and conflict by using devices.

3- Preserves inner harmony and helps the individual to make adaptation to distressing experiences.

4- To find justification in realistic ways for problem solving.

5- Provides psychic energy in keeping unwanted thoughts away from awareness.

6- Individuals may forget some of their most unpleasant problems and partially find effective ways of dealing with situations.

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- **Types**

- 1- **Repression/ selective forgetting**

- The involuntary exclusion of a painful or conflict thought, impulse, or memory from awareness. This is the primary ego defense mechanism.

- 2- **Reaction formation**

- Going to the opposite extreme; overcompensation for unacceptable impulses

3- Suppression

- An individual consciously decides to exclude an idea, desire, feeling impulses and tendencies from his thoughts and from his actions. It is a deliberate self control method.

- **4- Displacement/ transference**

  - A change in the object by which an instinctual drive is to be satisfied; shifting the emotional component from one object or idea to another.

a) Displacement physiological symptoms:

Person with anxiety experiences breathing problem and change in pulse pattern.

b) Displacement to change stimuli:

Phobias: fear of unexplained feelings or ideas.

5- Projection

Attributing one's thoughts or impulses to another person. In common use, this is limited to unacceptable or undesirable impulses.

6- Sublimation

- Attenuating the force of an instinctual drive by using the energy in other, usually constructive activities, Sublimation is often combined with other mechanisms, among them aim inhibition, displacement, and symbolization.

7-Compensation

- Encountering failure or frustration in some sphere of activity, one overemphasizes another. The term is also applied to the process of over-correcting for a handicap or limitation.

Direct compensation:

With unusual efforts, the individual overcomes his difficulties in the same field.

8- Denial

- The individual refuse to accept or to face the reality, he protect himself from unpleasant situations or unacceptable conditions.

9- Regression

Immature way of responding to stress and return to the previous status, in solving difficulties, an individual takes recourse to those methods which helped the individual in earlier stage of life.

10- Undoing

- An act or communication which partially negates a previous one.

11- Passive Aggression

- A person tries to gain something from others and to dominate it. It as attempt to hurt or destroy the source of frustration.
- Extra punitive:

The individual attributes the frustration to external persons or things.

Intropunitive:

The individual attributes frustration. The pent up feelings coming out through aggression gives relief and relief the tension.

12- identification

- Identification is a psychological act of taking other person's achievements as their own to drive satisfaction and success. They may identify themselves with a person or institution to meet their needs.

13- Emotional isolation

- It reduces emotional involvement, disappointments and protects the individual from harmful situation.

14- Escapism

An individual escapes from the condition which arouses expression of painful stimuli.

15- Inhibition Involuntary decrease or loss of motivation to engage in some goal directed activity to prevent anxiety arising out of conflicts with unacceptable impulses.

16- Fixation

- ž It refers to the point in the individual's development at which certain aspects of the emotional development do not advance. The reasons are not clear, but this arrest appears to develop from the inability of the individual to solve problems that occurred during the specific phase of development at which progress ceased or stopped.

17- Introjection

- ž Introjection is an act of identifying with other's values and norms to himself. It may lead to serious distorted adaptations when guilty feeling starts to function.

Stress and Stress Management

Stress: is a physical and emotional state always present in the person as a result of living ; it is intensified in a non-specific response to an internal or external environmental change or threat.

- Stress reactionsare purposeful and initially protective; the manifestation are physiological and psychological, structural and functional, overt and covert.
- On the positive side, stress helps to maintain equilibrium as well as increase motivation, learning, creativity, development, productivity, and satisfaction.

Complete freedom from stress is death or a nonexistent state.

In contrast, **Distress** is negative, noxious, unpleasant, or damaging stress. Distress occurs when needs can't be met or when well-being and integrity are threatened.

- Each period of distress leaves psychological and emotional wear and tear, which is sometimes irreversible.
- The terms stress and distress are often used interchangeably, although all stress isn't negative.

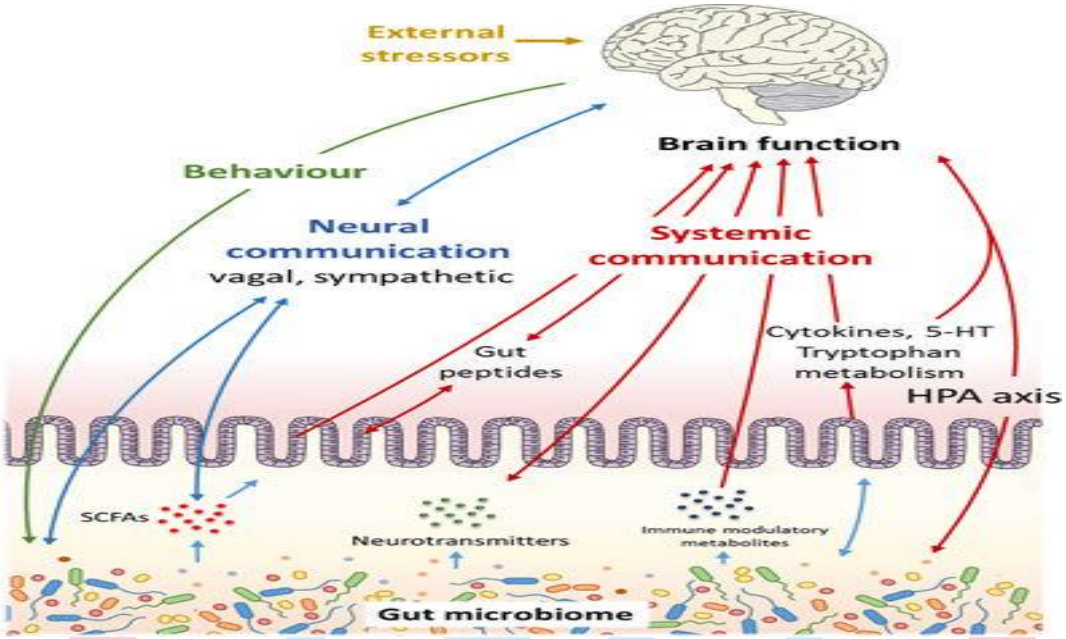
Stressors: tension-producing internal or external stimuli, agents, or factors placing a demand upon the body, and causing intensification of the stress state and disequilibrium.

In this table, lists stressors (stress agents) that may have emotional consequences:

1. Physical:	Excessive or intense cold or heat, sound, light, motion, gravity, or electrical current.
2. Chemical:	Alkalies, acids, drugs, toxic substances, hormones, gases, or food and water pollutants.
3. Microbiological:	Viruses, bacteria. Molds, parasites, or other infectious organisms.
4. Physiological:	Disease processes, surgery, immobilization, mechanical trauma, fever, organ hypo or hyper-function, or pain.
5. Psychological:	Anticipated marriage or death, imagined events. Intense emotional involvement, anxiety or other unpleasant feelings, distortions of body image, threats to self-concept, other's expectations of behavior, rejection by or separation from loved ones, role changes, memory of negative past experiences, actual or perceived failures.
6. Developmental:	Genetic endowment, prematurity, maturational impairment, or the aging process.
7. Sociocultural:	sociocultural background and pressures, unharmonious interpersonal relationships, demands of our technological society, social mobility , changing social mores, job pressures, economic worries, child-rearing practices, redefinition of sex roles, or minority status.
8. Environmental:	unemployment, air and water pollution, overcrowding, disasters, war, or crime.

- The exaggerated stress state occurs when stressors are excessive or intense, limits of adaptation are exceeded, and the person cannot cope with the stressor's demands.

- What is considered a stressor by one person may be considered pleasurable by another. The amount of stress in the immediate environment can't be determined by examining *only* the stressor or source of stress.



Predisposing Factors

A variety of elements influence how an individual perceives and responds to a stressful event. These "predisposing" factors strongly influence whether the response is adaptive or maladaptive.

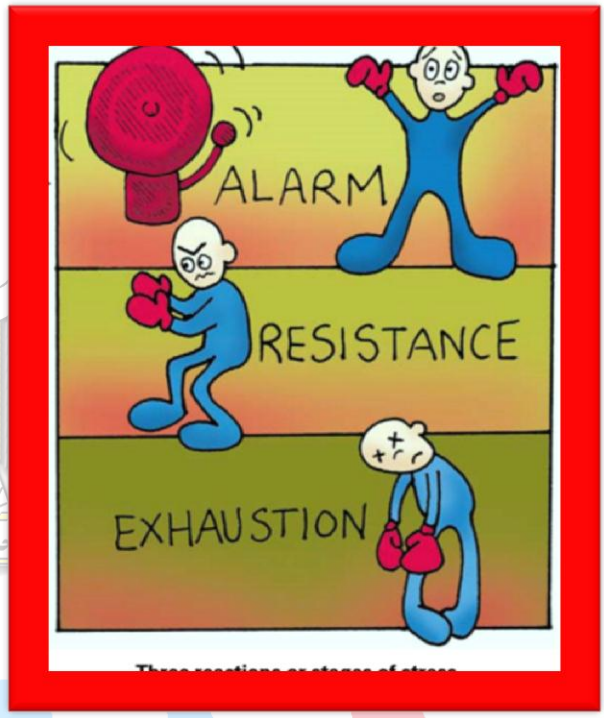
- *Genetic influences* are those circumstances of an individual's life that are acquired by heredity. Examples include family history of physical and psychological conditions (strengths and weaknesses) and the individual's temperament (behavioral characteristics present at birth that evolve with development).

- *Past experiences* are occurrences that result in learned patterns that can influence an individual's adaptation response. They include previous exposure to the stressor or other stressors, learned coping responses, and degree of adaptation to previous stressors.

- *Existing conditions* incorporate vulnerabilities that influence the adequacy of the individual's physical, psychological, and social resources for dealing with adaptive demands. Examples include current health status, motivation, developmental maturity, severity and duration of the stressor, financial and educational resources, age, existing coping strategies, and a support system of caring others.

- The person's survival and health status depends on the *intensity*, *duration*, and *location of the stress* and the *adaptive capacity of the person.*

Stress as a biological responsein three distinct stages:



1. **Alarm reaction stage:**
   During this stage, the physiological responses of the "fight or flight" syndrome are initiated.

2. **stage of resistance:**
   The individual uses the physiological responses of the first stage as adefense in the attempt to adapt to the stressor. If adaptation occurs, the third stage is prevented or delayed. Physiological symptomsmay disappear.

3. **Stage of exhaustion:**
   This stage occurs when there is a prolonged exposure to the stressorto which the body has become adjusted. The adaptive energy is depleted, and the individual can no longer draw from the resources for adaptation described in the first two stages. Diseases of adaptation (e.g., headaches, mental disorders, coronary artery disease, ulcers, colitis) may occur. Without intervention for reversal, exhaustion and even death ensues.

What can I do to stay mentally well?

Whether you have a mental health problem or not, there may be times or situations in your life that are more difficult than others. The capacity to stay mentally well during those times is called 'resilience'. Some ways you might be able to develop and strengthen your resilience, so that you can deal with everyday life and face difficult situations without becoming unwell.

- **1-Talk about the way you feel**

  If you are facing a difficult time, talking about the way you feel with someone you know and trust can often help. Your friends or family may be able to offer you practical help or advice and give you another perspective on what is causing your problems. Even if they can't help, often just talking something through and feeling that there is someone to listen and understand you can make you feel much better.

- **2-Build healthy relationships with people**

  Building and maintaining constructive relationships with people is an important part of staying mentally well. If you spend time around positive and supportive people, you are more likely to have a better self-image, be more confident and feel able to face difficult times. In return, if you are caring and supportive to other people, you are more likely to get a positive response from them. You are then more likelyto feel better about yourself and your ability to play an active part in society.
- If you do not have the social contact you need, or experience feelings of loneliness for whatever reason, this can also have a negative impact on your mental wellbeing.
- **3-Look after your physical health**

  If you have good physical health, you are more likely to have good mental health. Sleep patterns, diet and physical activity all have an impact on your mental wellbeing.
- **4-Sleep**

  If you have trouble sleeping, this can have a serious impact on your mental wellbeing. Negative feelings are likely to be exaggerated and you might find you are more irritable and less confident.
- **5-Diet**

  Eating healthily has a positive impact on your physical and mental health. Eating a well-balanced diet at regular meal-times with plenty of water and vegetables will help you to feel more healthy and happy. Avoiding tobacco and recreational drugs can also help improve your general wellbeing.
- **6-Physical activity**

  Physical activity is good for mental health, particularly if you exercise outdoors. Being active can help reduce depression and anxiety and boost your self-confidence. It also releases endorphins – 'feel-good' hormones that can help improve your mood. It doesn't matter whether you prefer gardening, gentle walking or something more active – you will almost always feel better for having done some physical activity.
- **7-Do something you enjoy**

  Doing something you enjoy can improve your confidence and help you stay well. Make time to do things you like, whether it's cooking, seeing your friends. Some people find that doing something creative, such as drawing, helps them to express themselves positively and deal with any difficult emotions in a positive way. Playing music helps me express feelings that are difficult to explain in words.

  Learning something new, or taking up a new hobby, can also boost your confidence and occupies your mind in a positive and active way. If you want to try a new hobby, think about what you are good at, or things that you have always wanted to try. You can find information about volunteering organizations, in local newspapers or magazines, or online.
- **8-Do something for someone else**

Doing something for someone else, such as helping a friend or relative, has been shown to have a positive impact on mental wellbeing. It can help you improve your self-confidence and meet new people, and makes you feel that you are making a positive contribution to your community.

- **9-Set yourself a challenge**

  Set yourself a challenge that you can realistically achieve. This doesn't have to be anything particularly large but should have meaning for you. For example, you might decide you are going to write a letter to your local paper or start going to a regular exercise class. You will feel satisfied and proud of yourself when you achieve your goal, and feel more positive about yourself as a result. I find that crafting not only helps me relax, but it also improves my confidence when I finish a project and I am happy with the results, especially if it's a gift for someone or something that improves the appearance of my home.

- **10-Relax**

  It's important to make time to relax, even if you don't feel under stress, spending an evening doing something you like, or even just taking a five-minute break to look out of the window. Learning a relaxation technique, such as breathing exercises, yoga or meditation, can also help you relax and reduce stress levels.

  Some people also find that alternative and complementary therapies, such as massage, acupuncture and reflexology, can help them relax and help them maintain their mental wellbeing. Remember – relaxation is not the same as recreation. Hobbies and other activities can become stressful if they become excessive.

- **11-Identify mood triggers**

  Keeping track of your moods in a mood diary can help you work out what affects your mental wellbeing and recognize changes in your mood. For example, you may realize that eating certain foods or seeing a certain person has an effect on your mood. Or you may tend to experience a particular mood at a particular time, such as in winter. Knowing what affects your moods can help you take steps to avoid or change the situations that have a negative impact on you. Even if you can't change the situation, knowing your triggers can help you remember to take extra care of yourself during difficult times. You can create your own mood diary.

- **12-Look after yourself during difficult times**

  Everyone has times when they face challenging situations and find it difficult to cope. If you are experiencing a difficult time, or are unwell, it's important to look after yourself and try and get through. Be careful not to put too much pressure on yourself to carry on as normal. You may need to take a break from your usual responsibilities, for example reducing your social activities or workload. Take small steps and don't expect too much of yourself. Try to get enough sleep and eat regularly. If you are finding it difficult to cope on your own, don't be afraid to ask for help. For example, you may need time off work

or help with day-to-day tasks, such as cleaning or childcare. Stay safe. If your feelings become overwhelming, and you have suicidal thoughts or you think you may self-harm, remember that you can pick up the phone at any time of night or day and talk to the Samaritans.

- **13-Learn to accept yourself**

The more I am at peace with myself and who I am, the more
I am likely to be at peace with others and who they are.
One of the most important steps in staying mentally healthy is to learn to accept you. If you value yourself, you are more likely to have positive relationships with other people and find it easier to cope with difficult times in your life.

Here are some tips to help you increase your self-esteem :

• Try not to compare yourself to other people.
• Don't strive for perfection.
• Acknowledge your positive qualities and things you are good at.
• Learn to identify and challenge unhelpful thinking patterns.
• Use self-help books and websites to help you change your beliefs.
• Spend time with supportive people.
• Be assertive – don't allow people to treat you with a lack of respect.
• Engage in work and hobbies that you enjoy.

What helped me was the realization that this is who I am,
to stop fighting it and realize that life may not be what you
expected it to be… Then, just start living again.
Learning to accept who you are can be very difficult, particularly if you are trying to do it on your own. If you feel that low self-esteem is having a significant impact on your mental health, you may find it helpful to talk your feelings through with a therapist.

What can I do to stay mentally well if I have a mental health problem?

Here are some tips that are directly relevant to maintaining your mental wellbeing if you have a mental health diagnosis.

- **1-Be involved in your treatment**

If you have a mental health problem, being involved in your treatment can help you stay well. Research shows that the more involved you are in decisions about your treatment, the more likely you are to recover from a mental health problem. Any mental health professional you see should discuss your treatment options with you, and you have the right to be involved in the decision-making process at every stage in your treatment.

- However, under compulsory treatment, the doctor in charge of your treatment can override your preferences if they think another treatment is the most appropriate one for your mental health problem at the time.
- **2-Manage your medication**

  If you are on medication, it is important to learn to manage this in a way that works for you. For example, if your medication makes you feel drowsy, you may want to ask your doctor if you could take it in the evening. Or you may find that you feel better if you avoid certain foods.

  If you experience side effects because of your medication, you should discuss this with your doctor or psychiatrist. They can help you decide whether to continue taking the medication and give you advice about how to manage any side effects.
- **3-Tell people what helps**

  Different things work for different people when they're unwell. Telling your friends, family and any medical or social care professionals what works for you can help them understand what you need if you become ill. For example, you may want to let your doctor know that a particular therapy or medication has worked for you in the past. Or you may want to tell your friends and family that it helps to talk through your feelings or that you prefer to be left alone. You may also want to make a crisis plan, or advance decision, to tell people what you want to happen if you are in crisis. This can help reduce stress and address any worries about what will happen to you or your family if you become ill.

What other support is available?

You may find that, despite your best efforts, you are unable to maintain your mental wellbeing on your own. In this case, you might want to seek professional help to address whatever is affecting your mental wellbeing.

- **1-Practical help**

  If there is a particular situation that is affecting your mental wellbeing, the best thing to do is to seek specialist practical help to resolve the problem. Having someone professional who is familiar with your type of situation can see it objectively and usually get to the root of the problem more quickly. For example, if:

  • You are caring for someone and finding the situation difficult,there are support groups that can help.

  • Problems at work are affecting your mental wellbeing, read your organization's policies to find out what rights you have and whatsupport mechanisms are available.

- **2-Peer support**

  Peer support means talking to people who have been through similar experiences; for example, in a support group. It can be a useful source of support and understanding. However, if you're accessing peer support online, think carefully about what information you want to share – you don't always know who you're talking to.

- **3-Mindfulness**

  Mindfulness is a way of paying attention to the present moment, using techniques like meditation, breathing exercises and yoga. It has been shown to help people become more aware of their thoughts and feelings, so that instead of being overwhelmed by them, it is easier to manage them.

- **4-Talking treatments**

  If you are facing problems that are affecting your mental wellbeing, and you can't resolve this by yourself, you may find a talking treatment helpful.

- Cognitive behavior therapy (CBT) is a form of therapy that aims to identify connections between your thoughts, feelings and behavior, and to help you develop practical skills to manage them. It has been shown to be particularly effective for low self-esteem and anxiety-based conditions.
- If your problems stem from early life experiences you might find that other talking therapies, such as person-centered therapy, psychodynamic therapy or interpersonal psychotherapy (IPT), can help you address these experiences more thoroughly.
- If you want to try a talking treatment, your doctor can provide information and refer you to a local service.

- **5-Medication**

  If you are unable to resolve any difficulties you are having yourself, and your feelings develop into a mental health problem, such as anxiety or depression, you may be offered prescription medication by your doctor. These drugs don't cure mental health problems, but aim to ease the most distressing symptoms.

- Many people find these drugs helpful, as they can lessen symptoms and allow them to continue with their normal activities. However, drugs can have side effects that may make some people feel worse rather than better. Your doctor should talk you through the potential advantages and disadvantages of taking any psychiatric medication and discuss possible alternative treatments.

Mental health problems in children and adolescents

Definitions

Mental health problems in children and adolescents can be mild to severe; some problems may last for a short period of time, and others may last a lot longer. They have a tendency to interfere with a child's or an adolescent's normal development, which includes their ability to function socially and/or psychologically. Specific childhood disorders include:

•• hyperkinetic disorders
•• conduct disorders
•• emotional disorders
•• social functioning disorders
•• other disorders – enuresis, encopresis
•• pervasive development disorders(Autism Spectrum Disorder DSM- 5).

There are also mental disorders that can start in childhood,including:

•• depression
•• anxiety disorders
•• adjustment disorders
•• psychotic disorders
•• sleep problems.

Disorders in adolescence include:

•• conduct disorder
•• eating disorders
•• mood disorders
•• anxiety disorders
•• obsessive-compulsive disorder
•• schizophrenia
•• substance misuse.

Clinical features

Mental health problems in children and adolescents according to age can present in different ways. For example, separation anxiety is common in younger children who worry about being separated from their parents or carers. Normally this fear subsides but for other children it can persist or reappear in adolescence, where it has an adverse impact upon their ability to function. On this basis it is important that a full assessment is carried out, which includes:

•• Interviewing the child or adolescent, their parents or carers, and their teachers.
•• Assessing the child's or adolescent's psychological, social and physical functioning and development.
•• Considering the family structure.
•• Assessing for signs of abuse or neglect.

Risk factors

The prevalence of mental health disorders in children and adolescents is between 10 and 20%, with boys having a higher prevalence than girls. The causes of these mental

health problems are not clear though there are risk factors that may increase an individual's vulnerability:

•• comorbid genetic disorder
•• physical health problems
•• poor educational performance
•• a comorbid mental health disorder
•• family difficulties
•• overprotective parents
•• parents with a mental health problem
•• stress, trauma
•• abuse or neglect
•• bullying
•• loss.

Management

•• cognitive behavior therapy
•• family therapy , •• group and individual therapy
•• solution-focused therapy.

Psychological interventions

When working with children and adolescents with mental health problems the mental health nurse needs to be competent in delivering the required interventions. The nurse may in some cases be supervised by a specialist in this area or they may be required to follow an agreed plan of care ,which may include:

•• therapeutically engage and support recovery
•• take a "strengths approach"
•• work in partnership
•• listen and respect the individual's experiences.

Aging population and mental health

Definitions

As individuals live longer we have an increasingly aging population, and mental health nurses need to be able to respond effectively to this change.

Generally a functional disorder is different from an organic disorder in that organic disorders result from an identified biological cause whereas in functional disorders there is no apparent biological cause.

Functional disorders in older adults include:

•• personality disorders
•• depression
•• anxiety disorders
•• mania
•• psychotic disorders.

The assessment, diagnosis and management of these functional disorders is the same for older adults as for younger adults.

Clinical features

The normal aging process may mean that an individual experiences a number of changes, which can be physical, psychological, social and spiritual. These changes and also how society generally views the aging process can have an impact upon the presentation, diagnosis and treatment of a given functional disorder:

•• Older adults are less likely to report low mood or suicidal thoughts.
•• Depression tends to be viewed as part of the aging process and due to this the appropriate treatment is not always given.
•• Certain psychiatric medications are to be used with caution where there is a coexisting physical illness.
•• Traumatic events such as a fall or a physical illness such as a stroke can lead to the onset of a functional disorder.
•• Mania is more likely to present in terms of irritability rather than overt elation.

Risk factors

Depression and anxiety disorders are the most common functional disorders diagnosed in older adults; the prevalence rates with all the functional disorders, except bipolar disorder, increase with age. Similar to functional disorders in younger adults the cause of functional disorders in older adults is not clear but there are a number of risk factors that may increase an individual's vulnerability:

•• the presence of a dementia increases the risk of depression
•• physical illness increases the risk of depression or mania
•• being socially isolated increases the risk of depression or a psychotic disorder
•• being in a nursing home or residential care increases the risk ofdepression
•• being a career for someone with dementia increases the risk of depression;
•• traumatic events increase the risk of an anxiety disorder
•• loss can increase the risk of depression or a psychotic disorder.

Management

Treatment is dependent on the functional disorder and its presentation, the individual's circumstances and their specific needs. Ensuring the individual is not socially isolated is a key part of the recovery process. In terms of interventions treatment guidelines recommend:

•• cognitive behavioral therapy – individual or group
•• treat any underlying physical illnesses
•• guided self-help
•• psycho education
•• group therapy
•• structured physical activity
•• behavioral activation
•• relaxation techniques
•• psychiatric medication
•• ECT in severe cases (depression).

Psychological interventions

When nursing older adults diagnosed with a functional disorder it is important that the individual is thoroughly assessed; this includes establishing whether there is an underlying physical condition. Also the risk assessment and management process needs to be sensitive to the increased risk of completed suicide in older adults. Depending on the skill of the nurse the types of interventions they may deliver are:

•• establish a collaborative therapeutic relationship
•• normalize an individual's experiences of mental distress
•• reduce by modifying thought processes and enhancing coping strategies
•• prevent social isolation and promote social functioning
•• problem solving
•• signpost to self-help and relevant support groups.

1- General rules related to psychotropic medications:

- The nurse should ensure that the patient receive his/her medication as prescribed. Some patients may refuse to take their psychotropic medication.

- The nurse should instruct the patient to continue to take medication, even if feeling well. Symptoms may return if medication discontinued.

- There should be a careful assessment of the medication therapeutic effects, the patient's view and understanding of the medication regimen.

- The nurse should reassure the patient that side-effects will be temporary and subside. In addition, the nurse should develop a plan of care to help patients deal with such side-effects in order to increase patient's adherence to medications.

2- Nurse's role toward side-effects of antipsychotics:

An important part of the psychiatric nurse's role is to identify, minimize, and intervene with side-effects experienced by the patients as a result of their medication regimens. The followings are the care in this respect:

- Patients should be instructed to rise slowly from a sitting or lying position, sit first with their legs dangling, wait for a minute, and sit or lie down if they feel faint, to prevent a sudden drop in blood pressure. Also, check blood pressure before giving medication in vulnerable patients can be helpful.
- Dry mouth can be a troubling symptom. The patient can be advised to rinse out their mouths frequently with water and to chew sugarless gum. Also, good oral care (frequent teeth brush) is very important.
- For constipation, encourage foods high in fiber, and physical activity.

- Oral antipsychotics may be administered with food to minimize gastrointestinal upset.
- Use caution when driving or operating dangerous machinery. Drowsiness and dizziness may occur.
- Patients are susceptible to photosensitivity. The patients should be instructed to not spend more than 30 minutes in sun, and should use sunscreens and wear protective clothing and sunglasses.
- Patients should be instructed to not drink alcohol while on medication. These drugs potentiate each other's effect.
- In relation to appearance of extrapyramidal side-effects, stay with the patient and offer reassurance and support during this frightening time. The antiparkinsonian (anticholinergics) drugs should be administered, e.g., Cogentin and Akineton.Prophylaxis with antiparkinsonian drug may prevent the development of such symptoms.
- In tardive dyskinesia, antiparkinsonian (anticholinergic) drugs should not be given; Inderal (beta blocker) should be administered.
- To control weight gain, develop a realistic plan for a balanced food intake and encourage physical exercises.

3- Nurse's role toward complications of antipsychotics:

Report occurrence of any of the following symptoms to the physician immediately: sore throat, fever, malaise, unusual bleeding, persistent nausea/vomiting, severe headache, muscle twitching, pale stool, yellow skin or eyes. If complications occurred, the drugs should be discontinued and appropriate medical treatment should be provided.

- **As related to a granulocytosis:**
  - Isolate the client.
  - White blood cell (WBC) count usually done every week, when the symptoms subside; it should be done every two months.
- **As related to obstructive jaundice:**
  - Bed rest and high protein and carbohydrate diet should be given.
  - Liver function tests every 6 months should be performed.
- **As related to neuroleptic malignant syndrome:**
  - Cool body to reduce fever.
  - Maintain hydration with oral and I.V fluids.
  - Correct electrolyte imbalance.
  - Arrhythmias should be treated.

4- Nurse's role toward compliance with medication:

Medication compliance is defined as the extent to which patients follow medication regimens and treatment instructions as prescribed by the health care providers. Patients who do not follow the medication regimen as prescribed are

known as noncompliant. A major challenge to nurses in the psychiatric practice is medication noncompliance or non-adherence. Previous studies reported that up to 80% of all psychotic patients do not take their medications as prescribed. Noncompliance leads to severe symptoms, relapse, frequent hospitalization, and significant costs.

There are many factors affecting patient's compliance with psychotropics, they may include:

- Lack of insight.
- Unpleasant side-effects.
- Suspiciousness.
- Stigma.
- Lack of knowledge about the illness and medication.
- Lack of support from psychiatric professionals and family members.
- Fear of addiction.

Psychosocial nursing interventions for improving medication compliance:

- The first step to improve drug compliance is to identify and recognize patient's reasons for noncompliance.

- Explore patient's attitudes, beliefs, and concerns about medications and their effects.

- Assist patients in acquiring knowledge about medications, including actions, precautions, side-effects, signs of toxicity, and drug interactions.

- Explain natures of and time span for onset of the drugs therapeutic results.

- Help patients to develop strategies for dealing with common side-effects and missing doses of medication.

- Relate medications to the target symptoms associated with patient's illness.

- Provide written and verbal instructions about medication to reinforce compliance.

Nurse's role for antidepressant drugs:

- Teaching the patient and family about tricyclic antidepressant.
- Tell them that the mood elevation may take from 7 to 25 days. It may take up 6-8 weeks for full effect you take place and for major depression symptoms to subside.
- Reassure the patient that drowsiness, dizziness, and hypotension usually subside after the first few weeks.
- When the patient starts taking tricyclic antidepressant, caution the patient to be careful working around machines, driving cars, because of possible altered reflexes.
- Alcohol can block the effects of antidepressants. Tell the patient to refrain from drinking.
- If the patient forgets the bedtime dose (or the once—day dose), the patient should take the dose within 3 hours; otherwise, the patient should wait for the next dose. The patient should not double the dose.
- Avoid sudden stopping TCAs. It can cause nausea, altered heart beats, nightmares and cold seats in 2-4 days.

Nurse's role:

1- Instruct the patient and the patient family to avoid certain foods that contain tyramine.
2- Instruct patient to go to the emergency room right away if he develop severe headache.
3- Ideally, blood pressure should be monitored during the first six weeks of treatment.
4- After stopping the MAOI, the patient should maintain dietary and drug restrictions for 14 days.

Nurse's role for use of SSRIs:

Patient and family teaching

- Because of the potential for drowsiness, patient shouldn't drive operate machinery until these side effects are ruled out.
- Avoid alcohol.
- Don't discontinue medication abruptly; abrupt withdrawal can lead to serotonin withdrawal syndrome.

Nurse's role in treatment with lithium:

The patient and the patient family should instruct about the following:

- Lithium can treat your current problem and will also help prevent relapse, so it is important to continue with the drug after the current episode is resolved.

- Lithium blood level should be monitored as mentioned before.

- Lithium is irritating to the gastric mucosa, so take it with meals.
- Periodic monitor of meal and thyroid functions is indicated with long term use.

- Seek nutritionist for sever weight gain.

- Careful health teaching is necessary so that the patient taking lithium can differentiate between side effects and toxic effects and understands what can cause a toxic increase in lithium levels and how to maintain a stable lithium level as ;

    - Teach the patient to **observe the tremor**. If it is due to expected side effects, it becomes mild and subsides after one week.
    - Maintain a **normal diet salt and fluid intake** (2500-3000 ml / day). Lithium decreased sodium re-absorption by the renal tubules which could cause Na^+ depletion. A low sodium intake causes a relative increase in lithium retention, which could lead to toxicity.
    - **Withhold the drug if** excessive diarrhea and vomiting occur. Dehydration can increase lithium level in the blood to a toxic level.
    - **Diuretics are contraindicated**.

Management for serious lithium toxicity:

- ➔ Lithium should be discontinued.
- ➔ Lithium level, serum electrolytes, renal function tests, and electrocardiogram should be obtained as soon as possible.
- ➔ Ensure adequate intake of sodium chloride to promote excretion of lithium.
- ➔ Vigorously hydrate: 5 to 6 liters/day; keep electrolytes balanced; IV line and indwelling urinary catheter.
- ➔ Implement peritoneal or hemo-dialysis in the most severe cases. These are characterized by serum levels between 2.0 and 4.0 m Eq/L.

Nurse's role for antianxiety drugs:

1. Observe any change in behaviors as ataxia or drowsiness.
2. Liver function test should be done every 2 weeks.
3. Measure blood pressure frequently.
4. Not consume other CNS depressants including alcohol.
5. Instruct the patient not to drive or operate dangerous machinery, drowsiness and dizziness may occur.
6. Instruct the patient not stop taking the drug abruptly. It can produce serious withdrawal symptoms.

7. Rise slowly from sitting or lying position to prevent sudden drop in blood pressure.
8. Report symptoms of sore throat, fever, malaise, easy bruising, unusual bleeding or motor restlessness.

NB:

- Never give diazepam IM because of poor absorption.
- Diazepam shouldn't be diluted with other solutions or mixed in the same syringe or bottle with other drugs; IV should be given slowly &directed carefully to the vein.

Nursing Care for ECT

Emotional support and education

Pretreatment nursing care

Providing quality nursing care for the patient receiving ECT include evaluating the pretreatment protocol to ensure that has been followed according to the hospital policy.

- This involves reviewing recommended consultation, nothing that any abnormalities in laboratory tests have been addressed.
- And checking that equipment and supplies are adequate and functional.
- A crash care with defibrillator should be ready available for emergency use .Patient preparation for ECT is similar to that for any brief surgical procedure
- General anesthesia is required, so fluids should be withheld from the patient for6-8hours before treatmentto prevent the potential for aspiration.
- The exception to this NPO status is in the case of patients who routinely receive cardiac medication and antihypertensive agents. These drugs should be administered several hours before treatment with small sips of water.
- The patient should be encouraged to wear comfortable clothing which include loose-fitting clothes, pajamas, or a hospital gown, preferably clothing that can be opened in the front to facilitate the placement of monitoring equipment.
- The patient' hair should be clean and dry to facilitate optimal electrode contact.
- The patient should void immediately before receiving ECT to help prevent incontinence during the procedure and to minimize the potential for bladder distention or damage

Nursing care during the procedure

The patient should be brought to the treatment suite either ambulatory or by wheelchair, accompanied by a nurse with whom the patient feels at ease.

- The nurse should remain with the patient throughout the treatment to provide support.
- On arrival the patient should be introduced to the member of treatment team and given a brief explanation of each person 'role in ECT procedure.
- The patient should then be assisted onto a stretcher and asked to remove shoes and socks.
- This allows for the placement of blood pressure cuff on an ankle and clear observation of the patient 's extremities during the treatment. Once the patient is positioned comfortably on the stretcher, a member of anesthesia staff inserts a peripheral intravenous line. One member of treatment team should explain the procedure while it is occurring.
- Electroencephalographic monitoring consists of two or more electrodes placed on the forehead and mastoid. A set of three –lead ECG is placed on the patient 's chest. A pulse oximeter is clipped to the patient ' s finger to monitor oxygen saturation
- Blood pressure monitoring throughout the treatment is accomplished by either manual or automatic cuff. A peripheral nerve stimulator helps to determine muscle relaxation.
- The patient 'a head is then cleansed with mild soap at the site of electrode contact. This cleaning process facilitates optimal stimulus electrode contact during treatment.
- Once the preparation is completed an ant cholinergic agent, such as glycopyrrolate (1.0- 0.4mg) or atropine(0.3-0.6mg), may be administered intravenously to decrease oral secretion and cardiac bradyarrthmias in response to the electrical stimulus.

- ❖ Next an anesthetic, usually methohexital, or etomidate(0.15mg/kg),is administered. When the patient is asleep the blood pressure cuff on the ankle is inflated, allowing it to serve as a tourniquet , so motor seizure activity can be visualized in that extremity. A muscle relaxant, succinylcholine(usual dose approximately 0.75 mg/kg) or rapacuronium (a nondepolarizing muscle relaxant recently approved by the U.S.Food and Drug administration (FDA)(usual dose 1.5 mg/kg) is then administered to minimize the patient 's motor response to the ECT treatment
- ❖ Progressive muscle relaxation is monitored by the nerve stimulator, as well as by observing the patient for the cessation of muscle twitching.
- ❖ As the muscle relaxant takes effect, the anesthesiologist provides oxygen by mask to the patient through positive pressure ventilation. Although most muscle become completely relaxed, jaw muscles are stimulated directly by the ECT, causing the patient's teeth to clench. This creates the need for a bite block to be inserted to the patient's mouth by the treatment nurse before the electrical stimulus .
- ❖ This device prevents tooth damage and tongue or gum laceration during the stimulus.
- ❖ The patient 's chin is firmly supported against the bite block during delivery of the brief electrical stimulus
- ❖ After delivery of the stimulus, the bite block may be removed.
- ❖ The electrical stimulus causes a brief generalized seizure.
- ❖ Motor signs of the seizure can be observed in the cuffed foot.
- ❖ Characteristic EEG changes also may be observed.
- ❖ One member of the treatment team records the time elapsed during the seizure.
- ❖ A seizure lasting 5-20 seconds is considered adequate to produce a therapeutic effect.
- ❖ Seizures lasting longer than 2 minutes should be terminated to prevent a prolonged postictal state .
- ❖ The seizure may be terminated by using a benzodiazepine, such as midazolam, or additional anesthetic given at have the induction dose.
- ❖ Anesthesia staff continuously ventilate the patient with oxygen during the procedure until the patient is able to breathe spontaneously.
- ❖ The nurse should monitor vital signs both before and after the ECT treatment.
- ❖ Once the patient is stabilized, the anesthesiologist clears the patient for transfer to the recovery area

Post treatment nursing care

❖ The recovery area should be adjacent to the treatment area to provide accessibility for anesthesia staff in case of an emergency.

❖ The area should contain oxygen, suction, pulse oximeter, vital sign monitoring, and emergency equipment.

❖ The area should be adequately staffed and provide minimal sensory stimulation.

- ❖ once the patient is in the recovery area with pulse oximeter in place, a staff member should observe the patient until awakening.
- ❖ When the patient awakens, a nurse should discuss the treatment and check vital signs as indicated.
- ❖ The nurse should provide frequent reassurance and reorientation at frequent intervals.
- ❖ Providing brief, distinct direction is most beneficial.
- ❖ When the patient appears ready to return to the hospital room, the nurse verifies that the patient 'vital signs, oxygen saturation, and mental status have returned to an acceptable level.
- ❖ Wheelchair transport from the recovery area is advisable
- ❖ The ECT treatment nurse provide been information about the patient to the nursing staff.
- ❖ This includes medications that have been given to the patient, as well as any change in the procedure that may impact the patient 'condition upon return to the unit.
- ❖ Patients should be observed at least once every 15 minute. If the patients is agitated, confused, or restless, one to one observation may be required until the patient 'condition has stabilized.
- ❖ If the patient is awake, the level of orientation should be assessed every 30 minutes until mental status returns to baseline.
- ❖ After assessing the return of the gag reflex, medications and a meal may be offered.
- ❖ When fully awake the patient should be on fall precautions.
- ❖ Any confusion or disorientation is likely to be of short duration.
- ❖ The patient may respond well to restricted environmental stimulation, and frequent nursing contacts focusing on reorientation are helpful.

Recovery

Introduction

Recovery as a therapeutic process is an integral part of mental health nursing practice. As a process mental health nurses often see recovery in terms of eliminating or controlling symptoms of mental distress. This view is quite a narrow, as recovery should be a whole-person approach where the meaning of recovery is embedded within the hopes and aspirations of the individual. Recovery is also about social inclusion where individuals are supported to live meaningful lives within society.

Competencies

Mental health nurses are required to:

•• Effectively engage with individuals with mental health problems in a way that is person-centered and also promotes social inclusion and recovery.

•• Ensure their practice is recovery-focused whatever the context or setting and that it values, respects and explores the meaning of an individual's mental distress.

•• Promote the self-determination and expertise of individuals with mental health problems while using their personal qualities and interpersonal skills to develop and maintain a recovery focused
therapeutic relationship.

•• Work with people living with mental distress, other professionals and agencies to shape services in a way that aids recovery.

The context

Utilizing a recovery-based approach presents a significant challenge for mental health nurses especially where there are professional and policy drivers for such an approach but no single agreed definition of recovery. On this basis recovery should be seen as being relative to the individual and their circumstances, meaning that the recovery process for that individual is being constantly redefined by their ever changing needs. The challenge for the mental health nurse in these circumstances is that they need to be both receptive and responsive to the service user's ever-evolving needs in a way that their practice is positively redefined by these experiences. Even though recovery as a process is relative in nature it can be seen to have aims that include:

•• promoting wellbeing

•• maximizing opportunity

•• empowering individuals to take control

•• facilitating and supporting the individual in finding meaning and purpose.

The recovery process

Recovery can also be described in terms of a process that includes
the following features:

•• A whole-person approach is taken rather than just focusing on
symptoms.

•• Recovery is viewed as a “journey rather than a destination”.
•• Optimism, commitment and hope are key values.
•• Support should be systematic but also innovative.

The components of recovery

There are a number of “models” of recovery such as the:
•• collaborative recovery model
•• strengths model
•• tidal model
•• wellbeing and recovery action plan approach.

The tidal model is particularly pertinent to mental health nurses as it has been created by mental health nurses in collaboration with mental health service users. As an approach the tidal model is made up of three key components or domains:
•• Self-domain – narrative or story-telling component.
•• World domain – where this narrative component is shared with others.
•• Others domain – this is where recovery is enacted through the care delivery process.

The recovery approach

The mental health nurse in the recovery process must be able to support the individual in a way that the individual’s story is actively valued as a core part of the care delivery process. The nurse must also recognize that interventions have to be outcome focused but they also have to be adaptable to changing need. Building on this the nurse must also be aware of the factors that positively influence the recovery process these include:
•• positive and sustainable relationships
•• meaningful activity
•• autonomy
•• resilience
•• personal growth
•• a healthy living environment
•• a supportive social network.

Physical health and wellbeing

Introduction

The role of the mental health nurse is to promote good physical health and wellbeing. This is especially important when considering that individuals diagnosed with a severe mental health problem are more likely to experience physical health problems than the general population. The first stage of promoting good physical health and wellbeing is to ensure that an individual's physical health needs are identified. This process should take the form of regular physical assessments; any needs identified should be addressed through an integrated and holistic package of care. Mental health nurses will also be required to deliver physical health care and/or signpost individuals to the appropriate services

Competencies

Mental health nurses are required to:

•• promote physical health and wellbeing through education, role modeling and effective communication

•• deliver physical care that meets the essential needs of people with mental health problems

•• recognize and respond to the physical needs of all individuals who come into their care

•• be able where required to signpost an individual with physical and mental health problems to the appropriate service.

The context

Physical health problems are common in individuals diagnosed with severe mental illness, such as depression, schizophrenia and bipolar affective disorder. The types of physical health problems include:

•• cardiovascular disease

•• respiratory problems

•• diabetes

•• digestive disorders

•• obesity;

•• musculoskeletal diseases

•• cancer – lung, colorectal and breast cancer

•• viral infections.

It is also important to recognize that physical ill health can lead to a mental health problem. It is not uncommon for enduring physical health problems to be comorbid with depression; these include:

•• cancer

•• heart disease

•• diabetes
•• musculoskeletal problems
•• respiratory problems.

Factors

There are numerous factors that may account for a higher incidence of physical ill health in individuals with mental health problems. These factors include:

•• Psychiatric medication – some medications increase the risk of obesity, diabetes and cardiac problems.
•• Lifestyle – individuals with mental health problems have a higher rate of smoking, and drug and alcohol misuse; they also tend to eat less well, and exercise less.
•• Social – indirect factors such as poverty, poor housing, and unemployment may also have an adverse impact.

There are also protective factors that keep mental health service users physically well, such as:

•• supportive and nurturing social networks
•• employment
•• self-awareness and having a sense of hope
•• having a healthy lifestyle.

Physical health assessment

Even when these factors are taken into account, individuals with mental health problems are less likely to have their physical health needs recognized compared to the general population. On this basis a physical health assessment should include:

•• the gathering of baseline physical health data including a medical history
•• a physical examination including baseline observations
•• baseline investigations including blood tests.

After the initial assessment the individual should be monitored annually, usually by their general practitioner.

Managing physical health

The mental health nurse's role in managing an individual's physical health is to be a health promoter; this includes:

•• providing education about medication and its side-effects
•• providing dietary advice or signpost to a dietician
•• promoting the benefits of physical exercise and monitoring weight
•• providing smoking cessation advice
•• liaising with the GP where required
•• signpost to family planning and sexual health services where required.

A key part of health promotion is to work collaboratively with the individual to change unhealthy behaviors by:

•• recognizing what behavior needs to change
•• developing an agreed action plan •• implementing the plan of action
•• providing encouragement however small the change
•• monitoring outcomes
•• developing agreed strategies that maintain change
•• if the change does not happen, try again.

ž Documentation

ž Introduction

ž Recording the planning and delivering of care is an important and
ž an essential part of mental health nursing practice. These records
ž should provide a clear and accurate record of the care delivery process;
ž they should also adhere to the guidance on record keeping of
ž the Nursing and Midwifery Council (NMC). When recording care
ž the mental health nurse will need to find a balance between their
ž professional view of a given situation and the service user's view;
ž they will then need to find an agreed viewpoint. To ensure that
ž there is a balance when recording care information this process
ž should be person-centered and collaborative.
ž
ž Professional competencies
ž Mental health nurses are required to:
ž •• Ensure they maintain records that are based on the best available
ž evidence and that these records are accurate, clear and complete,
ž whatever the format.
ž •• Fully participate in the care-planning process, which includes
ž completing relevant documentation and also evaluating the
ž outcome of any planned interventions.
ž •• Document care that fully identifies the service user's needs
ž including taking appropriate action where required.
ž •• Manage record keeping in a way that adheres to the relevant
ž Professional and legal frameworks.
ž The context
ž Professionally record keeping is viewed as "essential to the provision of safe and effective care". Records are also part of the communication
ž process where better communication means that there is a better quality of care delivered. For example, if a service user's condition is clearly and accurately recorded other members of the care team over time should be able to detect whether there have been any changes to the service user's condition and then act accordingly.
ž Certainly this is important where there are constant changes to the
ž personnel delivering care, such as in the case of shift-pattern working.
ž As mental health nurses work in different settings, within and also outside the NHS, then records may be kept in different formats from "paper" records to records that are only available in an " electronic" format. Whatever the format the principles of good record keeping remain the same as do the core professional values of individuality and partnership working. Types of records include:
ž •• handwritten clinical notes
ž •• emails and text messages
ž •• clinical letters
ž •• X-rays, laboratory reports and printouts

ž •• incident reports and statements
ž •• photographs and videos.
ž The function of documentation
ž Documentation is used in many contexts and is used for a number of purposes such as:
ž •• Improving accountability.
ž •• Presenting and supporting the clinical decision-making process.
ž •• Supporting effective communication.
ž •• Providing documentary evidence of the care delivered.
ž •• Supporting the clinical risk management process.
ž •• Supporting clinical audit, research and the complaints process.
ž Documentation standards
ž The following is a summarized list of those standards; it is recommended that the guidance is read in full:
ž •• Handwriting should be legible and all entries should be fully signed, with the date and time.
ž •• The entry should be accurate, factual and the meaning clear with
ž no unnecessary jargon.
ž •• Professional judgment should be used to decide what should be recorded.
ž •• Information related to a service user's care should be fully recorded.
ž •• Records should not be altered and/or destroyed without the relevant
ž authorization.
ž •• Any authorized alteration must be fully signed with the original entry record still clearly readable or auditable.
ž •• Ensure that the record-keeping process adheres to the relevant
ž professional and legal frameworks as well as national and local policies.
ž •• Service users and carers should where appropriate be involved in
ž the record-keeping process.
ž •• Information that is not clinically relevant should not be kept.
ž •• Service users need to be aware that their clinical records may be
ž seen by other people or agencies involved in their care.
ž Improving record keeping
ž It is essential that mental health nurses adhere to the professional
ž guidance on record keeping. But they also need to reflect on how
ž they can continually improve their practice. When engaging in this
ž process of reflection it might be useful to consider:
ž •• Does your entry provide accurate evidence of the standard of
ž care delivered?
ž •• Is it person-centered?

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