

SCHOOL OF SCIENCE AND TECHNOLOGY

**PRACTICAL PSYCHIATRY AND MENTAL
HEALTH NURSING**

BSN 3214P



**BANGLADESH OPEN UNIVERSITY
SCHOOL OF SCIENCE AND TECHNOLOGY**

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**SCHOOL OF SCIENCE AND TECHNOLOGY
BANGLADESH OPEN UNIVERSITY**

Introduction to the Module

Bangladesh Open University (BOU) has taken the initiative to bring its educational programs into the hands of those eager to learn. This module Behavioral Science-II, last of the two modules on Behavioral Science has been written with the same aim. Behavioral Science includes the fields of sociology, psychology and anthropology. In this module Behavioral Science -II, an attempt has been made to include an introduction to the subject (Unit-1) and sociology (Unit-2). In the second of the modules on the subject, Behavioral Science-II, an endeavor has been made to include psychology (Unit-1-4) and anthropology (Unit-5). Some of the lessons in one field may also be a lesson in another field, but for the convenience of the learner it has been put where it is in the module. The lessons have been so designed that they just give a basic idea of the topic under discussion.

Through this open schooling program the learner will be able to learn and develop new knowledge and skills, with the help of materials, without attending formal classes. This module is a bit different from those used in formal classroom situations. Before going through the module, carefully read the following points on how to use this book to get the maximum benefit.

Format of this Module

This book includes five units. Each unit has one or more lessons. Each unit has a unit-title followed by a brief introduction to the unit. A few lesson objectives are given at the beginning of each lesson. The important part in the text has been highlighted in boxes in the left margins. Beside the text, figures, diagrams, pictures, and flow charts—as applicable for clearer understanding of the subject supplement each lesson. A hypothetical problem, the exercise, is included in most of the lessons so that the learner can solve them in the light of the relevant lesson. This exercise will invite participation on the part of the learner to feel that s/he is an active participant in an exciting lesson. There is scope for self-evaluation at the end of each lesson. Both short true/false and essay analytical type of questions do this. The answers to the short questions are given at the end of the module.

How to Use this Book

- Read carefully the learning objectives of the lesson before going through the text.
- How much of the learning objectives have been achieved will be assessed by the learner at the end of the text.
- If the learner is not satisfied he/she will go through the text, as many times as necessary, until he/she is satisfied about the learning objectives.

- When the learning objectives are achieved, the learner will proceed with the exercise (questions). The answers to short questions may be checked with those at the end of the module.
- Unless one lesson is completed, the learner is advised not to proceed to the next lesson.
- It is advised that the learners preserve the solved exercises and answers to questions for quick reference before examination.

For Any Clarification

The learner is advised to listen and/or view the scheduled television and radio program by Open University on Behavioral Science.

The lesson to be discussed in the next program is announced at the end of each program. The learner should read the relevant lessons before the program. At the scheduled time, s/he should be ready with pen, paper and book in front of the television/radio set. The learner should take notes, if any part of the program is not understood. He/she should discuss these with the tutor in the tutorial class.

The tutorial classes are different from traditional classes, as the tutor will help only where the learner has difficulty. So the learner should go through the lessons and find out the difficult parts before going to the tutorials. The tutor will also advise and guide the learner for successful completion of the course. If the learner so wishes he/she could go through the books recommended for further reading. Moreover, the learners are strongly advised to use a standard English dictionary to facilitate comprehension.

Preface

The theme of Bangladesh Open University (BOU) is to make education available to the interested with minimum required traditional qualification, irrespective of other social differentiation, in an easy and economic way, without dislodgment from their daily routine. This education is mainly through, module based study which is self-contacted, self-directing, and self-pacing instructional material. In order to meet the national and international demand of graduate nurses, the Bangladesh Open University has introduced B. Sc. in Nursing program. One of the subjects of this program is Behavioral Science. It is expected that on completion of the program, the degree holders will be able to use his/her knowledge in the practical and professional life to meet the rising demand in health field.

A number of people have given their effort and time from the germinal position to the completion of this reading material, the module. Bangladesh Open University is grateful them. The contribution and guidance by Gail Crawford, Ph.D., of Athabasca University, Canada, who gave impetus in the early days of module drafting, had strengthened the conviction that such a course could take off. Before finalization, the draft reading material was tried out on a sample of target group, and necessary modifications made to accommodate the learner. Bangladesh Open University hopes this module will be able to attract the learners in turn with theme of the University. The University will appreciate any constructive criticism and suggestion for improvement of this module.

Practical Psychiatry and Mental Health Nursing

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Unit 1: Assessment of Psychiatric Patient

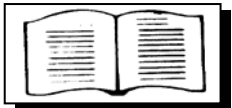
Assignment 1: Process Recording for Patient Admitted with Psychiatric Problem



1.1. Learning Objective

At the end of this assignment you will be able to-

- understand the patients' condition, family and environmental factors affecting his/her illness
- find out the past and present history of his/her illness
- make nursing diagnosis
- plan nursing intervention.



1.2. Nursing Assessment by History Taking

Nursing assessment is carried out for clinical information from patients through identifying potentials problems and to formulate plans for intervention. Psychiatric history includes the following-

1.2.1. Personal Data

- | | |
|-----------------------|-----------------------|
| ▪ Name of the patient | ▪ Age |
| ▪ Sex | ▪ Bed no |
| ▪ Ward No | ▪ Hospital Regd. |
| ▪ Marital status | ▪ Religion |
| ▪ Education | ▪ Occupation |
| ▪ Income | ▪ Language |
| ▪ Address | ▪ Nationality |
| ▪ Date of Admission | ▪ Date of examination |
| ▪ Clinical Diagnosis | ▪ Identification Mark |

2.2.2. Present Complaints or Problems During Admission

- Description of the patient problems
- Details of the nature of the problem and present severity of the symptoms
- Systematic enquiry about other relevant problems and symptoms
- Onset and course of symptoms and problems.

2.2.3. History of Present Illness

- a) The patient should be given enough time so that he can talk without hesitation about his problems in his own word.
- b) Details of the nature of the problem and symptoms
- c) Systematic enquiry about other relevant problems and symptoms
- d) Onset and course of symptoms and problems.

2.2.4. Family History

- Parents: Age (alive or death), occupation, personality and relationship with the patient
- Similar information about siblings
- Social position, atmosphere of the home
- Mental disorder in other members of the (extend) family and abuse of alcohol and drugs and anti-social behaviour.

2.2.5. Past History of Illness

- Previous history should be collected from the prenatal period till symptoms presentations.

2.2.6. Personal History

- Personal history include-
 - Mother's pregnancy and the birth process
 - Early growth and development
 - Childhood
 - Separation; broken home, over protection etc.
 - Emotional problems
 - Physical and mental illness (Psychological Problems)
- Schooling and higher education- age of starting school, level of education, performance, relation with teachers, class mates, peer groups
- Sexual relationships– (Premarital, extramarital)
- Menstrual history (in case of female patient)
- Marriage: Age of marriage, marital adjustment, if any
- Children: How many children, sex, maladjustment, specify the reason

- Social circumstances: Harsh up bringing
- Forensic history.

2.2.7. Past Medical History

2.2.8. Past Psychiatric History

Frequency of occurrence, month, year, season, and treatment.

History of Substance Abuse : If present

2.2.9. General Physical Examination

Body build:	Temp:
Nutritional status:	Heart:
Anaemia:	Lung:
Pulse:	Bowel:
B.P.:	Bladder function:
Resp:	Others:

2.2.10. Examination of Patients Mental Status

The mental status examination is a systematic enquiry of symptoms and signs related to certain mental states at the time of the interview.

- Appearance and behaviour
- Mood and Affect
- Speech
- Thought
- Perception
- Orientation
- Memory
- Insight
- Judgement.

2.2.11. Record of Laboratory Investigation: if any.

Proforma for Taking Psychiatric History

Case History

Ward No: Bed No:

Name of Informant:

Adm. Rg. No:

Relation with patient:

Psy. OPD. Reg. No:

Referred from/by:

Date of Admn.:

Reason for referral:

Date of Exam.:

History taken by:

Name of the Patient: **Age:** **Sex:** M/F.

Address:

Religion: **Habitat:** Urban/ Semiurban/Rural

Marital Status: Single/Married/Divorced/Separated/Widow/Others

Occupation **Education:**

▪ **Monthly Income:**

▪ **Chief Complaints During Admission**

▪ **History of present illness**

(Mention: onset/precipitating factor/Aggravation and relieving factors/
duration/ course/ level of functioning etc).

▪ **Family History**

Father:

Mother:

Siblings:

Consanguinity: Present/Absent

Social position of family:

Atmosphere of the home:

Family history of mental illness: Absent/ Present Mild, Moderate, Severe

If present

Disorder:

Treatment received:

Outcome:

▪ **Past History of Illness-**

▪ **Personal History**

- a) Birth history
- b) Early development
- c) Childhood (mention: neurotic traits)
- d) Schooling and education
- e) Occupation history
- f) Menstrual/Obstetrical history
- g) Marital history
- h) Sexual history
- i) Children
- j) Family type and environment
- k) Social circumstances

Past Medical History

(Mention: illness, duration, treatment and outcome)

Past Psychiatric History

(Mention: illness, duration, management and outcome)

History of Substance Abuse (If Present)

Premorbid Personality

Relationships:

Character:

Predominant mood:

Attitudes and standards:

Leisure activities (including hobbies): Habits (including drug use)

General Physical Examination

Body build:	Temp:
Nutritional status:	Heart:
Anaemia:	Lung:
Pulse:	Bowel:
B.P.:	Bladder function:
Resp:	Others:

Examination of Patients Mental Status (MSE)

1. Appearance and Behaviour

- a) General appearance:
- b) Facial appearance:
- c) Rapport
- d) Posture and movement
- e) Social behaviour
- f) Motor behaviour
- g) Oddity of behaviour

2. Mood and Affect

(Depressed/Anxious/normal/blunt/incongruity/lability/Depersonalization/

3. Speech

(Normal/ Incoherent/ Too little /Too much/ Mute etc, mention below)-

- a) Rate and quantity
- b) Volume and tone:
- c) Flow and Rhythm
- d) Oddity of speech (if any).

The characteristics or form of speech should be noted.

4. Thought

- a) Stream of thought
- b) Content (mention: obsession, delusion, Suicidal and homicidal ideation)
- c) Form of thinking

e.g., He or she misinterprets what happens. Keep note of any disorder of thought at the formation level, disorder at the stream of thought.

5. Perception

- a) Normal
- b) Hallucination
- c) Illusion
- d) Others if any

Assess for disorders of perception from your observation and interaction with the patients such as any illusions or hallucinations.

6. Orientation

Fully oriented to time, person and place.

7. Memory

- Immediate recall: it involves attention and concentration and ability to retain any material just learned.
- Recent memory you can ask the patient recall last 24 hours events or past few months.
- Remote memory to recall important facts during her/ his child hood.

Asking the patient the date of his admission to the hospital, the name of the person who brought him to the hospital, are the examples of Recent Memory. Immediate memory is assessed to record the patient's grasp of repeating such pairs of words as head-hair, room-hall, table-chair or patient just repeat the digits within a 10 second interval forward than backward.

8. Insight

Ask the patient questions to assess his insight into his present state of illness. The patient says he has no problem at all. This shows complete lack of insight.

9. Judgement

Judgement of the patient will depend on his or her knowledge, educational level, intelligence and alertness.

10. Laboratory Investigation

11. Treatment as Prescribed by Doctor

Sample of Patient's Mental Status Examination (MSE)

1. Identifying Data:

Name:

Sex:

Age:

Ward No.

Date of doing M.S.E.

2. General Appearance and Behaviour

3. Talk and Speech

Language

Bangla

Reaction Time

Normal

4. Mood and Affect

Pleasant eg:

- in a good mood

Subjectively

- says, I am alright

Objectively

- appears to be calm, quiet but sad looking

Affect

- inappropriate

5. Thought

At formation level eg:

- self muttering present

At content

- no impairment

At progression level

- no impairment

6. Orientation

About festivals and his surroundings Prime Minister's name. Has some information about cricket, etc.

Fully oriented to time, person, and place.

7. Memory

Immediate

Recent

Remote

8. Perception

Illusions and hallucinations.

9. Insight

Why are you admitted to this hospital? The patient replies I get slight headache that is why I am hospitalised.

10. Judgement

Logical. When asked what will he do if he finds a wounded child on roadside? He said, "I would take him to hospital" When asked what will he do before taking the child to the hospital. He said, he would bandage if the child were bleeding.

11. Attention

Can be easily aroused.

Concentration-fair sustained for a fairly long time.

Special Points

Bowel and bladder	- Regular
Appetite	- Decreased
Sleep	- Normal sleeping pattern
Libido	- Normal

12. Psychosocial Factors

Stressors: Internal and External - Coping skills: patient uses various coping skills as escaping difficult situation or going to a friend for an advice.

Relation As in the personal history, relationship of the patient at various stages of development. You may ask from the patient and validate from the relative.

Cultural

Spiritual

Occupational

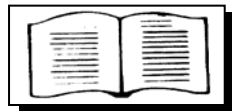
Assignment 2: One Day Care Plan

2.1. Learning Objective



At the end of this assignment you will be able to-

- assess the patients needs and problems
- understand nursing diagnosis
- establish short term and long term goals
- make nursing care plan according to patients needs
- implement care plan to the patients
- monitoring evaluate the patients condition after implementing care
- replan if necessary.



2.2. Nursing Assessment

Nursing assessment is done by taking proper nursing history including person's biographical and health details.

Nursing history can be taken in the following ways.

Sample Form for Taking Psychiatric History

Case History

Ward No: Bed No: Name of Informant:

Admn. Rg. No: Relation with patient:

Psy. OPD. Reg. No: Referred from/by:

Date of Admn.: Reason for referral:

Date of Exam.: History taken by:

Name of the Patient: **Age:** **Sex:** M/F.

Address:

Religion: **Habitat:** Urban/Semiurban/Rural

Marital Status: Single/Married/Divorced/Separated/Widow/Others

Occupation **Education:**

Chief Complaints:

History of Present Illness:

Family History

▪ **Past History of Illness**

- **Personal History**

b) Past Medical History

(**Mention:** illness, duration, treatment and outcome)

c) Past Psychiatric History

(**Mention:** illness, duration, management and outcome)

d) History of Substance Abuse (If any)

e) Premorbid Personality

General Physical Examination

Body build:

Temp:

Nutritional status:

Heart:

Anaemia:

Lung:

Pulse:

Bowel:

B.P.:

Bladder function:

Resp:

Others:

Systemic Examination

(Nervous system/other systems)

Mental Status Examination (MSE)

1. Appearances and Behaviour

- a) General appearance
- b) Facial appearance
- c) Rapport
- d) Posture and movement

- e) Social behaviour
- f) Motor behaviour
- g) Oddity of behaviour

2. Moods and Affect

(Depressed/Anxious/normal/blunt/incongruity/lability/Depersonalization/
Derealization/ others:)

3. Speech

(Normal/ Incoherent/ Too little /Too much/ Mute etc, mention below)-

4. Thought

5. Perception

6. Orientation

Fully oriented to time, person and place.

7. Memory

8. Insight

9. Judgement

10. Laboratory Investigation

2.3. Nursing Diagnosis

To identify the problem.

2.4. Objective set up- assesses the patient’s needs and problem. Objective may be-

- long term
- short term.

2.5. Care Plan

Sample of One Day Care Plan

Patient	Objective	Care Plan	Implement	Evaluation
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Assessment of Psychiatric Patient

Needs /Problem				
Neglect personal hygiene	To maintain personal hygiene	Encourage to wear clean cloths - To assists To explain needs of cleanness		
Knowledge deficit about jaundice.	Provide adequate knowledge about jaundice.	Provide health teaching to the patient and visitors Take feedback from them. Observe the practice of patient and visitors after health teaching.	Organised health talk for patient's and relatives about what is jaundice, causes, clinical features, care and handle of body secretion, urine stool. Taken feedback from relatives. Observed their practice.	Patient and his relatives gain knowledge about jaundice.

2.6. Implementation

2.7. Evaluation

2.8. If Necessary Replan

A Case Study of a Patient with Dementia

Identifying Information

Mrs Hasina in a 50-year-old widow living alone in a house. Her brother, who states, referred her: "She has been extremely forgetful recently." She lives on her husband's retirement and also receives Social Security.

Client's Description of the Problem

Mrs Hasina comes to the clinic this morning at the request of her brother, stating, "I had nothing to do with it. My brother's daughter must have a

friend here. “She states that she has been feeling “confused” and cannot remember things “from one moment to the next.” She cannot remember how long this has been going on. Mrs Hasina states that nothing unusual has happened over the past year. She is able to provide limited information about her present problem. According to Mrs Hasina’s 40-year-old brother, she has become increasingly disoriented over the last 6 months. On his own initiative, he brought her to the doctor, who was unable to find anything physically wrong. Her brother describes her as “forgetful and just not herself.” On occasion, when he has gone to visit her, he has found her door unlocked and the burner on the stove left on.

Psychiatric History

No prior psychiatric history.

Family History

According to Mrs Hasina her husband of 60 years “dropped dead two years ago while watching TV.” She has one brother who is married with one daughter and lives nearby, and a daughter, 32 years old, married with three children and lives “in another district.”

Social History

Mrs Hasina appears to have had a normal adulthood, passing through developmental milestones such as marriage, parenting, grand parenting, retirement, and widowhood without any problems. Mrs Hasina has no formal occupational training. Mrs Hasina spends most of her days in her house.

Health History

There is no history of major illness or injuries. Mrs Hasina states that her appetite is “so-so,” while her brother says she seems to have lost weight. When asked if she had any difficulty sleeping, she responded defensively, “No! No! No!”.

Current Mental Status

Mrs Hasina is a cooperative elderly woman who appears somewhat unkempt with uncombed hair, wrinkled dress. She is oriented to person and place, knows the year, but is unsure of the month and date. Her general knowledge is poor, and she is unable to name the nearest five friends. Mrs. Hasina is alert, labile, superficial, sporadically anxious, and irritable. She denies having illusions, hallucinations, or delusions. She shows loose associations but can be redirected easily.

Objective Clinical Data

She is not on any medications; suicide/ violence potential minimal.

Diagnostic Impression/ Nursing Diagnoses

- Sleep pattern disturbance
- Altered Nutrition
- Altered Thought Processes.

2.2.Objective set up- assesses the patient’s needs and problem. Objective may be.

- Long term
- Short term.

2.3. Care Plan

Patient Needs /Problem	Objective	Care Plan	Implement	Evaluation
Sleep Pattern Disturbance related to Dementia.	Patients will sleep 8 hours at night.	Offer milk or horlickes at bedtime. Allow client to wander in a prescribed area until she gets tired. Daily schedule for activities.		
Altered Thought processes related to memory loss.	Patients will maintain optimal cognitive functioning.	Structure environment to enhance memory (clocks, calendars, orientation board).		
Altered Nutrition: less than body requirements related to	Patients will not lose weight; will take in adequate daily	- Have family member and nurse monitor food and fluid intake. - Supervise at mealtimes and		

loss of memory (client forgets to eat).	amounts of food and fluids.	assist as necessary. - Give diet high in protein and carbohydrates in finger-food form with double portions. - Weigh patients weekly. Help family plan strategies to ensure patients eats enough each day.		
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2.4. Implementation

2.5. Evaluation

2.6. If necessary Replan

Another Sample of One day Care Plan

Nursing Diagnosis

A Client Experiencing Dementia.

Expected Outcome

Client will-

- Have stable vital signs
- Remain free from injury
- Consume 1500 cal and 2000 cc of fluid each day
- Verbalize thoughts and feelings
- Sleeps 6-8 hr/ night
- Participate in self-care to ability
- Demonstrate trust with caregivers and family.

Assessments, Tests and Treatments

- Mental status exam on admission and day of examination

Assessment of Psychiatric Patient

- Vital signs 4 hr if stable
- Intake and output
- CBC and urine analysis
- Chemistry profile, electrolytes
- Folate level
- Chest X-ray
- EKG
- Other diagnostic tests as indicated
- Assess need for HIV testing
- Weight
- Assess mood, affect, and behaviour 1-2 hr
- Assess bowel and elimination patterns and sleep patterns
- Initiate bowel protocol.

Knowledge

- Orient client and family to room and routine.
- Use simple words and phrases.
- Include family in teaching.
- Review plan of care.
- Assess understanding of teaching.

Diet

- Encourage up to 2000 cc of fluids each day (unless contraindicated).
- Limit caffeine intake.
- Provide frequent, small, nutritious feedings, inclusive of all food groups.
- Nutrition assessment including calorie count if indicated.

Activity

- Assess safety needs and maintain appropriate precautions.
- Frequent observation.
- Activity as tolerated.
- PT evaluation if indicated.
- Assist with hygiene.

Psychosocial

- Assess level of anxiety.

- Provide information and ongoing support and encouragement to client and family.
- Use simple commands.
- Approach in calm, quiet manner.
- Assess sleep patterns and provide measures that promote rest and sleep.
- Encourage expression of thoughts and feelings.
- Approach in non-judgemental manner.
- Explore availability of support system.
- Explore interests.

Medications

- Routine medicine as ordered.
- PRN medicine for agitation.

Consults and Discharge Plan

- Family assessment if not previously complete.
- Refer to neurologist and/or psychiatrist if indicated.
- Establish discharge objectives with family member.

Unit 2: Communication Skills

Assignment 1: Health Education to the Patient's Family or Community

1.1. Learning Objectives



At the end of this assignment you will be able to-

- what is meant by health education for psychiatric patient
- communication aspects of health education
- understand emotional state of patients in the psychiatric wards.



1.2. Introduction

Traditionally, nurses have been actively encouraged not to get emotionally involved with their patients and families. This is now changing, and what is considered important is coping by being involved, with the emphasis on holistic care. Coping by being involved requires developing interpersonal communication skills, and learning basic counseling skills. This means becoming a caring communicator, which requires the ability to demonstrate warmth, respect, genuineness and empathy. It also means learning to question, to listen, and when and how to be assertive.

1.3. Definition

Health education of psychiatry includes activities, which enhance well being and diminish ill health as well as those which influence the knowledge of health professionals.

Health education includes activities, which enhance well being and diminish ill health.

Though WHO defined health as a state of complete physical, mental and social wellbeing and not merely an absence of disease or infirmity, but this concept is not always clear in a area like psychiatry, where the main problem lies with inbalance or conflict between self and others or self and the environment.

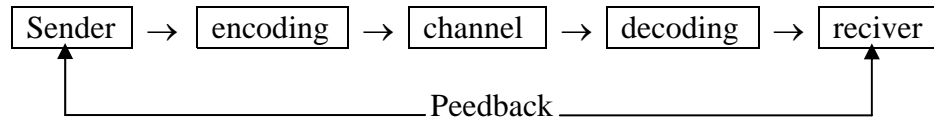
However, we can remind here about some basic concept of health education which are as follows-

1. Health education is primar education related of health.
2. It is need-based.
3. It is not ontime affair.
4. Communication is the main tool.

Communication Skills

5. Correct knowledge is necessary for communications.
6. Motivation is possible if successful communication implied.

Communication is done by following 5 steps.



The main purpose of communication is to transfer correct messages to the patient, attendant or relatives. Psychiatric cases are delicate and critical because of its nature. So, nurses should be more technical and knowledgeable when handle psychiatric patients.

Nurses have to distinguish 3 parts of receivers-

1. the patient
2. his family, friends or attendants and
3. the community.

Communication should be articulated or transmitted according to the target group. Health education can be successful if the total response of the nurses would satisfied the patients towards cure or improvement.

We already talked that main task of health education depends in the main communication. Successful communication means clear understanding of the message between sender and Receiver with same meaning. For communicating patient's relatives, or community, now will discuss the basic steps of communication.

1.4. Basic Communication's Steps

A. Verbal Communication

1. Volume
2. Pitch or tone
3. Rate
4. Meaning of words

B. Non-Verbal Communication

1. Facial expression
2. Eye contact

Six Communication

- Verbal
- Non-verbal
- Asking question
- Listening
- Assertive communication
- Avoid

3. Posture
4. Gesture
5. Behaviour
6. Touch
7. Appearance
8. Warmth
9. Respect
10. Empathy

C. Asking Questions

1. Open and closed questions
2. Gentle questioning.

D. Listening

1. Passive listening
2. Active listening.

E. Positive or assertive communication should be applied to express the situation or reality.

F. Confrontation must be avoided.

1.5. Practical Behavior Necessary for Psychiatric Nurses

Understanding the emotional state of a patient in psychiatric ward/hospital, we must judge the emotional states, consider positions, and know how to show respect and how to say “no” in an accepted way.

1.5.1. Judging Six Basic Emotions

1. **Happiness** (smiling mouth, and wrinkles around the eyes).
2. **Sadness** (raised brows, lowered upper eyelids and a down-turned mouth).
3. **Anger** (lowered brows are drawn together, the lips are drawn together, the eyes may stare).
4. **Disgust** (the nose is wrinkled, the upper lip raised, the brows are lowered).

Six Emotions

- Happiness
- Sadness
- Anger
- Disgust
- Surprise
- Fear

Communication Skills

Four Zones of Distance

- Intimate ($\leq 18''$)
- Personal (1-4')
- Social (4-12')
- Public ($\geq 12'$)

5. **Surprise** (the mouth opens wide and the jaw drops, the brows are raised and the eyes open wide).
6. **Fear** (the brows are raised and drawn together, the eyes are wide open, as is the mouth and the lips drawn back tightly).

1.5.2. Four Zones of Position/ Distance

1. **The intimate zone**, 45 cm (18 in). Normally reserved for lovers and close family; touch is important; whispering can be heard.
2. **The personal zone**, 0.5-1.2 m (1.5-4 ft). Touch is less important; visual cues can be seen.
3. **The social zone**, 1.2-3.7 m (4-12 ft). For more formal contact, such as conducting business; may have a barrier such as a desk. Speech and visual cues are important.
4. **The public zone**, 3.7 m (12 ft) or more. This is the distance a public speaker is placed from an audience.

1.5.3. Ways of Showing Respect

1. When you meet for the first time, **greet** and introduce yourself.
2. Give your undivided **attention**.
3. Determine how the other person likes to be addressed, and make a conscious effort to **remember** their name.
4. Refrain from gossiping about other patients or colleagues, which would question your ability to keep a **confidence**.
5. Allow **time** for others to talk, ask for their views, do not interrupt.
6. If you have a limited time **announces** this in advance.
7. If you are late or have to cancel an appointment, **explain** the reason and apologize.

Five ways of Hello

- Greet
- Attention
- Remember
- Refrain
- In time

1.5.4. How to say “no” to Unreasonable Requests

1. State your refusal very near the beginning of the reply.
2. Indicate briefly your reason.
3. Communicate your understanding of the requester’s problem.
4. Suggest an alternative solution.

All these must be present in a steady, clear and warm voice, maintaining good eye contact.

1.5.5. How to Convince the Relatives

Believe, that you
can. You will be
successful.

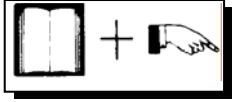
Most of the psychiatric problems originated either from 'self' or from the 'family' or 'community'. Nurses should be very careful to handle the patient's relatives. In many cases, psychiatric problem has inheritant link, i.e., the family has a positive history. So, conversation or interaction must be careful.

1.6. Summary

Nurses should understand the complexity of human communication. Caring communication comes from an awareness and sensitivity of the verbal and non-verbal messages being broadcast, knowing how to listen, and demonstrating warmth, empathy and respect. On occasion it calls for the ability to communicate assertively, and how to manage confrontation.

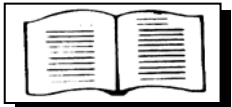
Assignment 2: Observation Report of the Psychiatric Patient

2.1. Learning Objectives



At the end of this assignment you will be able to-

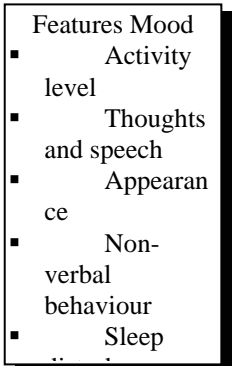
- observations of major psychiatric disorders and substance abuse generally found in patients department of hospital
- care plan for the psychiatric patients
- Identify and manage some special situation.



2.2. Introduction

In psychiatric wards, we generally receive major types of psychiatric disorders and drug addict patients-

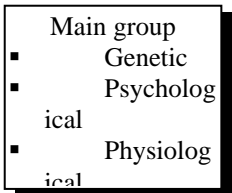
- Manic, depressive
- Anxious, compulsive
- schizophrenic and
- drug addict.



All the psychiatric patient would be carefully observed by-

- i) Mood
- ii) Activity level
- iii) Thoughts and speech
- iv) Appearance and non-verbal behaviour
- v) Sleep disturbance
- vi) Sexuality
- vii) Appetite.

The main causes can be assessed through-



1. Genetic and biochemical factors- mood disorders inherited resulting in biochemical changes
2. Psychological factors- mood disorders arise from developmental problems in childhood, early loss, helplessness and negative thinking.
3. Physiological factors- mood disorders are precipitated by drugs, physical illness or childbirth
4. Psychosocial factors- loss, change and other stressful life events cause coping problems and mood disorders.

Nursing care strategies should be planned through carefully studied above observation. The main objectives of nursing care might be as follows-

- maintain a **safe environment** and protect other patients
- establish **healthy communication** and relationship
- establish a reasonable **sleep pattern**
- establish adequate **eating and drinking**
- establish adequate **hygiene**
- establish adequate **elimination**
- establish **constructive** levels of **activity**
- establish appropriate expression of **sexuality**.

The treating policies and steps should be done accordingly but special attention must be given to the specialized group, i.e., schizophrenic and others.

2.3. General Observation

- Gesture
- Position
- Appearance
- Talking pattern
- Behavioral attitude
- Response.

2.4. Specific Observation

- Types of disorder
- Depression level
- Signs of mania
- Therapeutic reaction
- Communication
- Eating and drinking
- Working, playing and motilities
- Self-harm level
- Safety.

Communication Skills

All observation must be noted in written form to present the case during round. Indicative factors, i.e., psychological and physical conditions should be presented with, equal emphasis on extrinsic factor such as environmental and behavioral aspects. Assessment should be concluded by general and specific observation.

As an example, a schizophrenic patient may have many complaints like, manic, neurotic or depressive. The nurses should explore the maximum concern of the patient, which is more to any specific disorder. Rest part of management would be done by the doctors.

Here, we can remind you that presenting a psychiatric patient do not mean to forget his natural or demographic particulars. So, be careful about the followings-

1. Biographical data
2. Past health history
3. Present illness (detail of this part may be presented with general and specific observation)
4. Social history
5. Employment/ job history
6. Physical function.

The end stage of assessment results in a conclusion about problem or needs, and is derived from a comprises between the patient's normal functioning and changes brought about the present health status.

Please remember again, problem statement or observation report should have 3 parts-

- a. What the problem is
- b. What is caused by
- c. How it affects the patient.

2.5. Summary

It is important to classify the patient by assessment. Health education always depends and differs on category of the patient. So, observation and reporting is of vital importance. Patient may change their level or shift from initial diagnosis to other. Nurses should understand and change the health education technique in accordance to the need and prescription.

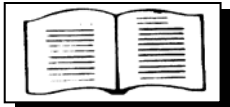
Assignment 3: Management Techniques of the Psychiatric Patient

3.1. Learning Objectives



At the end of this assignment you will be able to-

- what to do for what
- care plan for main 4 groups of psychiatric illness
- management of special problems like manipulative aggressive and parricidal.



Note carefully the four sections hereafter distinguishes by their observational characteristics in psychiatric ward.

A. Care Plan for Manic Patient

The input and output of water and electrolytes maintain these

Problem	Nursing Action
1. Risk of aggression or accidents	<ul style="list-style-type: none"> ▪ Increase observation levels ▪ Reduce environmental stimuli ▪ Protect other patients
2. Communication impaired due to- - Irrational, grandiose speech content - Speeded up thoughts and speech	<ul style="list-style-type: none"> ▪ Reduce reinforcement of bizarre speech ▪ Divert/distract from bizarre speech ▪ Limit set on sexual speech content
3. Sleep disturbance	<ul style="list-style-type: none"> ▪ Single room comfortable bed ▪ Non-stimulating environment
4. Inadequate food/fluid intake	<ul style="list-style-type: none"> ▪ Check weight weekly ▪ Cater for needs/preferences ▪ Flexible approach
5. Impaired cleansing and dressing	<ul style="list-style-type: none"> ▪ Supervision and prompting ▪ Use a clothing checklist ▪ Limit setting to protect dignity
6. Constipation/urinary retention	<ul style="list-style-type: none"> ▪ Encourage hydration ▪ Gentle prompting

Communication Skills

A. Care Plan for Manic Patient

7. Overactivity	<ul style="list-style-type: none"> ▪ Reduce environmental stimuli ▪ Encourage non-competitive activities ▪ Protect other patients
8. Increased libido and disinhibition	<ul style="list-style-type: none"> ▪ Increased supervision ▪ Protect other patients ▪ Limit setting

B. Care Plan for Anxious Patient

Problem	Nursing Action
1. Self-harm risk (Anxiety symptoms/ panic attacks).	<ul style="list-style-type: none"> ▪ Assess and care as for self-harm, depressed patient ▪ Increased observation ▪ Minimize trigger factors ▪ Teach anxiety management techniques.
2. Impaired communication Self-harm.	<ul style="list-style-type: none"> ▪ Calm approach ▪ Physical presence/contact ▪ Constantine activities as diversion ▪ Adult praise ▪ Province opportunities to success.
3. Withdrawn/restless (Insomnia, Anorexia, Diarrhea/frequency of micturition Sexual dysfunction/ menstrual problems, other physiological and behavioral manifestations of anxiety).	<ul style="list-style-type: none"> ▪ as of 1 and 2

C. Care Plan for Schizophrenic Patient

Problem	Nursing Action
MAINTAINING A SAFE ENVIRONMENT	
1. Imagined environmental threats	<ul style="list-style-type: none"> ▪ Allow patient opportunities for self-expression
2. Episodes of agitation or	<ul style="list-style-type: none"> ▪ Conservative measures

aggression	<ul style="list-style-type: none"> ▪ Discreet observation ▪ Active measures (offer medication, engage patient in activity)
COMMUNICATING	
3. Mistrust of others	<ul style="list-style-type: none"> ▪ Clear, truthful communication
4. Inappropriate speech	<ul style="list-style-type: none"> ▪ Reinforce normal conversation
5. Lack of social skills	<ul style="list-style-type: none"> ▪ Demonstrate and provide opportunities for patient to practice these
6. Social withdrawal	<ul style="list-style-type: none"> ▪ Consistent encouragement to gradually increase participation
EATING AND DRINKING	
7. Refusal to eat, through belief food poisoned/ medicated	<ul style="list-style-type: none"> ▪ Allow patient to select meal from trolley ▪ Encourage patient to buy and prepare own provisions ▪ Ask relative to bring in what patient desires ▪ Nurse offers to taste patient's food ▪ Provide balanced food, enabling patient to season it himself.
PERSONAL CLEANSING AND DRESSING	
8. Indifference to appearance	<ul style="list-style-type: none"> ▪ Provide incentives for improvement (praise, financial reward) ▪ Enable patient to select and purchase own toiletries and clothes ▪ Ensure warmth and privacy for maintaining personal hygiene ▪ Provide an inspiring role-model for patient
WORKING AND PLAYING	
9. Lack of social contact in community	<ul style="list-style-type: none"> ▪ Arrange outings ▪ Encourage visitors, correspondence, opportunity to

Communication Skills

	receive telephone calls and overnight home stays
10. Employment difficulties	<ul style="list-style-type: none"> ▪ Liaise with statutory agencies (social welfare dept., Employment Rehabilitation Centre)
11. Lack of self-sufficiency after discharge	<ul style="list-style-type: none"> ▪ Place patient and relatives in touch with Charitable Association

D. Care Plan for Alcoholic (or Addicted) Patient

Problem	Nursing Action
1. Ataxia, restlessness, impaired vision	Constant observation; remove obstacles; provide assistance, adequate lighting, reassurance, sedation as prescribed.
2. Visual hallucinations	Ensure adequate, even lighting at all times and illusions avoid shadows; provide rational explanations without antagonizing patient.
3. Tachycardia, hypertension, dyspnoea, pyrexia	Monitor patient's pulse, blood pressure, respirations and temperature as patient's condition warrants.
4. Disorientation from 'here and now' reality	Reorientate patient as appropriate; offer 'true' perspectives diplomatically.
5. Overambitious future aims	Help patient towards critical appraisal of self and goals; involve relatives where feasible.
	Be inwardly sceptical; show interest only in genuine therapeutic effort/discussion; refer to self-help group.
6. Alcoholic dehydration	Encourage high oral intake (fruit juice, squash, water). Manage intravenous infusion, if required.
7. Nutritional neglect	High protein diet Vitamin supplementation Reverse effects of deficiency Regular weight checks.

8. Personal neglect	Thorough inspection, cleansing and provision of clean clothing following admission (treat infestation as necessary).
9. Pyrexia, excessive perspiration	Regular bed-baths, sponging, used deodorants, fanning.

Management of the Manipulative Patient

- | |
|---|
| <ul style="list-style-type: none"> ▪ Be consistent ▪ Show unconditional positive regard ▪ Confront inappropriate behaviour without anger ▪ Do not coax, bargain or rationalize ▪ Reinforce desirable behaviours, withdraw reinforcers when behaviour unacceptable ▪ Role model 'acceptable' behaviour ▪ Be aware of peer group pressure ▪ Avoid 'special' relationships ▪ Be sensitive to effect on ward team: ▪ Explore effects on other patients. |
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Management of the Aggressive Patient

- | |
|---|
| <ol style="list-style-type: none"> 1. Accept that verbal aggression is normal and can be healthy 2. Develop strategies to anticipate and minimize aggressive incidents 3. Remain, or try to remain calm, confident and objective 4. Do not be a hero; avoid one-to-one confrontations 5. Some one assistance if necessary: be aware of local alarm systems 6. Restraint, if used should be the minimal amount necessary to effect the required result 7. Strive to preserve the self-esteem of the patient throughout 8. Following the incident arrange for patient and, if necessary, staff to be examined for any injury 9. Arrange on the spot briefing to help avoid recurrences 10. Record fully, using the appropriate documentation. |
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Management the Parasuicidal Gesture

1. Initiate or participate in first aides required
2. Recognize that the person may genuinely want to die
3. Assess depth of suicide risk
4. Maintain a safe environment
5. Look out for trigger incidents
6. Avoid value judgments
7. Avoid over identification
8. Discourage exaggerated use of sick role
9. Address loss of self-esteem
10. Set realistic short-term goals.