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NATIONAL OPEN UNIVERSITY OF NIGERIA

SCHOOL OF SCIENCE AND TECHNOLOGY

COURSE CODE: NSS401

COURSE TITLE: MENTAL HEALTH AND PSYCHIATRIC NURSING I

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GUIDE

NSS401
MENTAL HEALTH AND PSYCHIATRIC NURSING I

Course Team Dr. J.A. Afolayan (Writer) - NDU
Prof. A. Adebanjo (Programme Leader) - NOUN
Kayode S. Olubiyi (Coordinator) - NOUN

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National Open University of Nigeria
Headquarters
14/16 Ahmadu Bello Way
Victoria Island
Lagos

Abuja Office
No. 5 Dar es Salaam Street
Off Aminu Kano Crescent
Wuse II, Abuja
Nigeria

e-mail: centralinfo@nou.edu.ng
URL: www.nou.edu.ng

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Mental Health and Psychiatric Nursing I is intended for learners, practitioners and facilitators in the field of Nursing who will find the information in this course useful and easy to apply in a variety of practice settings. Students in fields like nursing, social work, physical therapy, recreational therapy, occupational therapy, rehabilitation etc will find explanations of effective and maladaptive human behaviours as well as the most current therapeutic interventions and treatments.

This course will develop in you the knowledge and skills needed for meeting the ever changing needs of the clients/patients and families.

The Course

The course consists of 16 units, which includes introduction to mental health and psychiatric nursing, mental health and mental illness concepts, current issues and trends of care in mental health, characteristics of mental health, factors affecting mental health, healthy mental health environment, conceptual models, sources of mental health problems in the youths, coping devices and defence mechanisms, the therapeutic nurse-patient relationship, causes of mental illness, general signs and symptoms of psychiatric disorders, classification of mental disorders, stress and mental health, personality disorders, psychiatric emergencies, and disorders of childhood psychiatry.

This Course Guide tells you briefly what the course is all about, the reference books and how you can successfully go through the course. Tutor-Marked Assignments are also provided at the end of each unit.

Course Aims

The aim of this course is to present you a concise insight into mental health and mental illness in nursing and ways of meeting these nursing demands in your day to day services rendered to mankind.

Course Objectives

After going through this course, you would be able to:

- define health, illness, disorders, mental health, mental illness, psychiatry, psychiatric nursing
- describe the current issues and trends of care in mental health
- state the characteristics of mental health
- explain the factors affecting mental health

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- althy mental health environment
- onceptual models of mental health
- list the sources of mental health problems in the youths
- discuss the coping devices and defence mechanisms
- describe the therapeutic nurse-patient relationship
- state the causes of mental illness
- explain the signs and symptoms of psychiatric disorders
- classify mental disorders
- describe stress and mental health
- explain personality disorders
- list the psychiatric emergencies
- discuss the disorders of childhood psychiatry.

Working through this Course

To complete this course you are required to read the study units (1-16) read the reference books and any other materials provided by the National Open University of Nigeria. Each unit has Tutor Marked Assignment at the end. You will need to create enough time for each unit for you to be thorough in the acquisition of knowledge.

Course Materials

The major components of the course are:

1. Course Guide
2. Study Units
3. References/Further Readings

Study Units

The units of this course are as follows:

Module 1

Unit 1 Introduction to Mental Health and Psychiatric Nursing
Unit 2 Mental Health and Mental Illness Concepts
Unit 3 Current Issues and Trends of Care in Mental Health
Unit 4 Characteristics of Mental Health
Unit 5 Factors Affecting Mental Health

Module 2

Unit 1 Healthy Mental Health Environment
Unit 2 Sources of Mental Health Problems in the Youths

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Defence Mechanisms
ness
ymptoms of Psychiatric Disorders

Module 3

Unit 1	Classification of Mental Disorders
Unit 2	Stress and Mental Health
Unit 3	Personality Disorders
Unit 4	Psychiatric Emergencies
Unit 5	Disorders of Childhood Psychiatry I
Unit 6	Disorders of Childhood Psychiatry II

Module 1: Units 1 and 2 contain the basics of the course such as definitions of health, illness, mental health, mental illness, psychiatry, psychiatric nursing. Unit 3 presents the current issues and trends of care in mental health. Unit 4 takes the learner through the characteristics of mental health. Unit 5 teaches the factors affecting mental health.

Module 2: Unit 1 is on healthy mental health environment. In unit 2, the learners will be taken through the causes of mental health problems in youths. Unit 3 is on the coping devices and defence mechanism used in our day to day living while Unit 4 is on the causes of mental illness. Unit 5 deals with the general signs and symptoms of mental disorders.

Module 3: Unit 1 is on classification of mental disorders while Unit 2 deals with stress and mental health while Unit 3 is on various personality disorders. Unit 4 takes you through some psychiatric emergencies and Units 5 and 6 deals with Disorder of Childhood Psychiatry.

Each study unit consists of introduction, specific objectives, main contents, conclusions, summary, tutor marked assignments and references/further readings.

Textbooks and References

Adedotun, A. (2000). *Basic Psychiatry and Psychiatric Nursing.* Ile-Ife: Basag (Nig) Enterprises.

Burr, J. (1970). *Nursing the Psychiatric Patient* (2nd ed). London: Bailliere Tindall and Cassell.

Fish, F. J. (1967). *An Outline of Psychiatry*. Bristol: John Wright & Sons Ltd.

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M. (2005). *Foundations of Mental Healthcare*. sby, Inc.

Olatawura, M. O. (2002). Psychology and Psychiatry, (Ibadan Lecture series). Ibadan: Spectrum Books Limited.

Staurt, G. W. and Lavaia, M. T. (2001). *Principles and Practice of Psychiatric Nursing,* (7th ed). Missouri: Mosby Inc.

Sreevani, R. (2004). *A Guide to Mental Health and Psychiatric Nursing.* India: Jaypee Brothers Medical Publishers (P) Ltd.

Stellenberg, E. L. and Bruce, J. C. (2007). *Nursing Practice Medical-Surgical Nursing for Hospital and Community* (2nd ed). London: Churchill Livingstone.

Udoh, C. O. *Mental and Social Health,* Ibadan: Distance Learning Centre.

Verghese, M. (1994). *Essentials of Psychiatric and Mental Health Nursing*. New Delhi: Churchill Livingstone PVT Ltd.

Tutor-Marked Assignment

The Tutor-Marked Assignment is the concurrent assessment of the course which accounts for 30% of the total score for now. You are expected to answer the number of the tutor marked assignments which will always be decided by the university and the same submitted to your facilitator for grading before you are allowed to write the final examination in the course.

End of the Course Examination

The final examination on this course is expected to cover a three hour duration which has a value of 70% of the total course grade.

Summary

This course intends to provide you with underlying knowledge in some basics in mental health and psychiatric nursing and upon the completion of this course; you are better prepared for the second course in mental health and psychiatric nursing so that you can meet the current challenges ahead of professional practice as a nurse. You will be able to answer such questions like:

i. What is health?

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iv. What is mental illness?
v. What is mental health-mental illness continuum?
vi. What are the current issues and trends of care in mental health?
vii. What are the characteristic of mental health?
viii. What are the factors affecting mental health?
ix. How can we achieve a mentally healthy environment?
x. What are the sources of mental illness in the youths of our society?
xi. What are the coping devices and defence mechanisms?
xii. What are the causes of mental illness?
xiii. How can we explain the general signs and symptoms of mental disorders?
xiv. How can mental disorders be classified?
xv. What is stress?
xvi. What are personality disorders?
xvii. Describe the psychiatric emergencies.
xviii. What are the disorders of childhood psychiatry?

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Abuja Office
No. 5 Dar es Salaam Street
Off Aminu Kano Crescent
Wuse II, Abuja
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Unit 1 Introduction to Mental Health and Psychiatric Nursing
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UNIT 1 INTRODUCTION TO MENTAL HEALTH AND PSYCHIATRIC NURSING

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  3.5 Misconceptions of Psychiatry
4.0 Conclusion
5.0 Summary
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7.0 References/Further Reading

1.0 INTRODUCTION

This course deals with mental health and psychiatric nursing by looking into the basic concepts. This course focuses on the various definitions, special fields of psychiatry and misconceptions of psychiatry.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- explain the concept of health
- discuss the concept of mental health
- define the concept of psychiatry
- discuss the concept of psychiatric nursing
- list various special fields of psychiatry
- identify the misconceptions of psychiatry.

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TENT

3.1 Concept of Health

ñHealthò is a word that has a common use. It features prominently in consumer goods advertisement, especially with those dealing with food, drugs and cosmetics. It also features in our everyday conversations, good wishes and greetings. It is expressed either implicitly or explicitly and has become the concern of every individual, family, community and the government.

It is a term that was not defined in any precise way until when the World Health Organisation put forth its definition which has now been accepted as a standard definition among health practitioners. The Organization defined health as ña state of complete physical, mental and social well-being and not merely absence of disease or infirmityò. There are two parts to this definition. The first part sees health as ña state of complete physical, mental and social well-beingò and the second part views health as not necessarily the ñmere absence of disease or infirmityò. This first part of the definition clearly points out the fact that health has at least three dimensions or components ï mental, physical and social components. The second part confirms the above view by clearly pointing out that the absence of disease and infirmity does not mean that health necessarily exists. In other words, health cannot be determined by observing or evaluating the physical or physiological status of a person.

Over the years, the World Health Organization definition remained supreme, but later some authorities in health education began to question some aspects of the definition. Take a look at the definition again. The questionable aspect is that which speaks of a state of complete physical, mental and social health. Although health is usually considered positive, there is no question of its completeness, because it fluctuates on a continuum. At any moment, health may be located anywhere on this continuum. If located near the extreme positive end of the continuum, it would represent the highest level of health. But if located at the opposite end, it would represent a low level of health. Therefore a state of completeness is ruled out because no one ever attains the highest level of optimum health. However a location of health status at the low level of health is the beginning of ill-health and that absolute low level of health is death.

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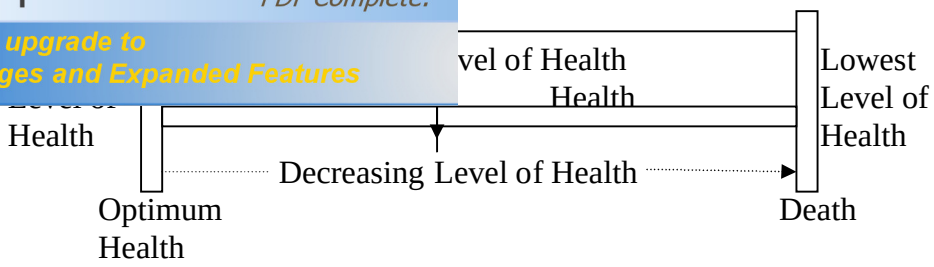

Fig 1: Health – Illness Continuum

As a result of the limitations in the WHO definition some other definitions have arisen. These are not necessarily more satisfactory than the WHO definition, but they clearly show the area of emphasis of the respective authors. Such definitions include:

1. Health is a quality, resulting from the total functioning of the individual in his environment that empowers him to achieve a personally satisfying and socially useful life (Johns *et al, 1975).*

An analysis of this definition shows that there are four components ï (i) as the unity of the individual, (ii) as a quality of life, (iii) as an achievement of personality satisfying life, and (iv) as an achievement of socially useful life.

2. Health is that state or quality of life which enables an individual to face up to crisis, carry out his daily responsibilities efficiently and relate to other persons effectively.

The above definition gives health the pride of place. By implication, only the person who is in health can function in any meaningful way and the functional level is dependent on the level of health such a person is enjoining.

3. Health is that quality which enables one to ñlive most and serve bestò (Williams, 1933).

This is a more philosophical definition which could be said to be a summary of the definition it follows. Only a person in health can be in a position to ñlive most and serve bestò.

When you wake up in the morning, stretch yourself and throw up your arms and yell, ñI feel wonderful and good this morningò, that is an evidence of health. Health is the most prized possession of human beings, although man often takes it for granted until he begins to lose it.

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beings are made up of many parts which take their of cells which differentiate into organs and systems ony while health exists. He is made up of physical, mental and social dimensions, each distinct in character, yet functioning as a unit. Since these dimensions function as a unit, it then implies that whatever affects any of the other parts brings about certain changes in the other parts or causes disequilibrium in the individualôs constitution to a point whereby his/her functioning is either slightly or grossly impaired.

Being in health has much to do with the degree of disequilibrium factors affecting an individualôs normal life. This degree determines where a personôs place is on the continuum of health mentioned earlier. Being in health has nothing to do with whether an individual is a midget, a giant or physically disabled. A person is regarded as being in health if in spite of the three examples of conditions mentioned above, he is able to function effectively, physiologically, mentally, intellectually and socially within his limitations.

Although a discussion of health usually takes the form of separate treatments of the physical, mental and social components of individuals, this is purely for convenience. In practice, as you should have observed from earlier expressions about an ailment affecting a part of the body, there is no such thing as separate and distinct physical, mental and social health. This implies that health is considered as it affects the totality of an individual and not just a part of him.

Let us examine the following situation. You might say ñmy head achesò but not that ñmy head is illò or ñmy head does not enjoy health todayò. Although there are times you might say ñmy fever is better todayò or that ñmy head is alright nowò, but the more natural and rational expression might be to say, ñMy headache is curedò. The disposition of a person due to headache or his freedom from ache is a condition, just like a variety of other conditions which positively or negatively affect the status of such an individualôs total health that is, his physical, mental and social health combined. These dimensions are inseparable. They are the factors which make an individual a unique personality and which set him out from any other individual.

Since health fluctuates on the health continuum, it is therefore a quality of life which results from oneôs total functioning within oneôs physical, biological and social environment. Effective living is also a result of a personôs functioning in a variety of lifeôs situations which include his physical, mental, social and spiritual experiences. What you do ï such as your work, leisure activities, social engagements, food habits, your

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ll combine to determine your quality

The concept of quality of life therefore implies that what is important is not necessarily how long one lives, although long life is desirable, but how well one lives, how fulfilling, fruitful and satisfying the existence has been. Many people take good health for granted especially when all is well with them. Its importance is quickly realized when good health gives way for illness or poor body functioning. The best way to protect and maintain health is through the acquisition of scientific knowledge with regards to health matters, the adoption of positive attitude towards health and the practice of good health habits.

Health is a phenomenon which transcends the individual. Although most individuals are concerned with their personal health, there is more to it as it is also concerned with the home as well as the community to which the individual belongs. It is therefore incumbent on everyone who has achieved good health to seek for the welfare of members of his family and community. A person who is in the peak of health but surrounded by squalor and filthy environment and hunger cannot be considered healthy. Good health requires an achievement of a socially useful life, as well as maintaining good physical, emotional and spiritual wellbeing

3.2 Concept of Mental Health

3.2.1 What Is Mental Health?

Mental health has not been easy to define because of several views associated with it. However, a synthesis of these views holds that mental health is the adjustment which a person makes to himself as well as to the society, so that he faces realities of life and functions most effectively with the greatest satisfaction and cheerfulness in socially acceptable ways. In other words, a mentally healthy person is one who is able to control his emotions and adequately meets variety of situations he comes across in his environment; one who possesses a sense of self-esteem, insight to things and self-acceptance.

Mental health is a state which is completely abstract because an onlooker does not know what is going on with an individual, but its manifestations are generally observed in the individualôs overt behaviour or adjustments which the individual makes in response to his environment, be it physical, biological or social.

The way a person adjusts to his/her environment portrays his personality ï that is, the sum total of his traits and characteristics which makes each person different from any other person. No two persons are exactly alike

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espond to the environmental stimulus or stress, e similar in some ways.

It is this abstractness of mental health which is generally manifested by overt behaviour and its uniqueness to individuals, its fluctuation from time to time with even the same individual and its dependence on a host of other factors that have made it difficult to draw a distinct line between mental health and mental ill-health because of the problem of identifying where one ends and the other begins. Sometimes they appear to overlap. This means that no single characteristic or attribute can be taken as evidence of positive mental health status nor can the lack of any of these characteristics or attribute be an evidence of mental ill-health.

3.2.2 Definitions of Mental Health

You would have observed from what has been said above that an absolute definition of mental health remains a problem. It is thus easier to use the description of mental illness in order to bring out the meaning of mental health, since any abnormal behaviour is clearly a manifestation that all is not well with the exhibitor of that behaviour. A person whose behaviour is deemed abnormal is obviously not enjoying good mental health by societal expectations. The assumption is that when a person behaves in a way approved by a rational society, such a person must be experiencing good mental health. There are obvious limitations in this assumption because it neither shows clearly the level of mental health being enjoyed by a person nor the difference between a high and low level of health which is considered below normal.

Some authorities have provided definitions or descriptions of their conception of mental health. While each is bedeviled by the limitations such as identified above, a synthesis of all these represented below gives a clear picture of what mental health is. By the time you have studied them, you should be able to provide your own definition or description of mental health. Let us look at what some of these authorities such as Fansworth (1957), Johoda (1958), Maslow (1959), Glasser (1960) and Johns *et al* (1962) has to say.

Fansworth (1957) defines mental health as a state of mind in which one is free to make use of his capacities in an effective and satisfying manner. Mental health implies a moderate amount of self-understanding, the capacity to be creative, the ability to love and accept love, and to think in terms of other people rather than on oneself only.

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...lthy person as one who:

1. ...ing his own motivation drives, wishes and desires;
2. Accomplishes self-realisation and self-actualisation;
3. Has an integrated and balanced personality.

Maslow (1959) sets out his hierarchy of basic human needs, the fulfillment of which is believed to promote mental health.

These include:

1. Physiological needs (food, sleep, sex etc.).
2. Safety and security needs.
3. Love (or belongingness) need.
4. Self-esteem need.
5. Self-actualization need.

Glasser (1960) sees mental health as being synonymous with responsibility. He defines responsibility as the ability to fulfil oneôs needs and to do so in a way that it does not deprive others of their own ability to fulfil their own needs as well. He also sees the individual as having two basic needs; the fulfillment of which he contends would engender positive mental health:

1. The need to love, and be loved.
2. The need to feel worthwhile to both self and others.

Johns, Sutton and Webster (1962) define mental health as ñthe quality of personal health resulting from the individualôs satisfaction of human needs through personal and social adjustments in his environmentò. Such an adjustment will enable the individual to:

1. Face his problems realistically.
2. Make choices from several alternatives.
3. Cope with oneôs emotions maturely and skillfully.
4. Work efficiently and live effectively.
5. Contribute to the improvement of the society.
6. Find satisfaction in success and happiness in carrying out oneôs own role in life.

A synthesis of all the above description or definitions of mental health indicates that:

1. Mental health requires emotional stability and maturity of character; as well as the strength to withstand strains and stresses

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ociety without undue physical and psychological

2. Mental health implies the ability to judge reality accurately and to see things in their true perspective and in terms of their long term rather than short-term values.

3. Mental health means the ability to love and to be loved as well as to be able to sustain affectionate relationship with others. This demands the presence of affectionate conscience, realistic, independent and at the same time a practical code by which to live.

4. Mental health demands satisfaction of needs such as basic physiological need, security need, self-esteem and self-actualisation need in such a way that neither self nor other persons are hurt.

5. Mental health requires the development of autonomy by gaining independence of action and orientation towards becoming, as well as the ability to master life as it comes, to cope with inter-personal relations and group belongingness and to achieve happiness in life.

3.3 What is Psychiatry?

Psychiatry is a branch of medical science which deals with the study and treatment of mental diseases. It deals with the mind, emotions and behaviour of man ï scientifically, the least understood aspects of the human animal.

Psychiatry is the branch of medicine which deals with the diagnosis, treatment and prevention of mental illnesses. Psychiatric illness is characterized by a breakdown in the normal pattern of thought, emotion and behaviour. Psychiatric problems and illness of all kinds are extremely common throughout life.

3.4 Special Fields of Psychiatry

(a) Child Psychiatry: Child psychiatry deals with the diagnosis and management of psychiatric problems that have their onset in childhood. Two important factors are very dominant, the tremendous influence of the environment and the plasticity of the childôs mind. In the environment, the attitude of the parents, difficulties at school and the relationship and attitude of

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...rs and teachers play a very important

(b) **Geriatric Psychiatry:** Geriatric Psychiatry is the study of mental disorders affecting old people. Perhaps unwisely, age 65 is traditionally accepted as the arbitrary dividing point between adult psychiatry and geriatric psychiatry. Some medical practitioners specialize largely in geriatric medicine and some Psychiatrists spend most of their time in geriatric psychiatry, often as Consultants in homes for the elderly or to public agencies concerned with the welfare of old people.

(c) **Forensic Psychiatry:** The phrase ñForensic Psychiatryò will include all aspects of psychiatry which remain in close and significant contact with the law, legislation or jurisprudence, including, but not limited to, problems in the psychiatric aspects of testamentary capacity, criminal responsibility, guardianship evidence, competency, marriage, divorce, custody of children, commitment procedures, personal injury evaluation, malpractice litigation, preservation of the civil rights of the mentally ill, addiction to alcohol and drugs; psychiatric testimony in courts and before other tribunals or legislative bodies, management and treatment of all offenders and confidentiality of records. Thus forensic psychiatry is a general term that denotes the interface between Law and Psychiatry.

(d) **Adolescent Psychiatry:** Adolescence ï the period between puberty and young adulthood (approx. 12 ï 17 years) is marked by a great surge of physical development and major social and psychological adjustments. It begins a year or so earlier in females than in males both psychologically and emotionally. There are marked endocrinologic changes during this phase of life. The ñnormalò adolescent almost always shows evidence of emotional turmoil and personality change. The adolescent who shows no emotional uphill is apt to be repressed and is actually failing to deal with the problems of this phase of life.

(e) **Community Psychiatry:** This is a new but realistic approach of the psychiatrists and other members of the psychiatric team of preventing, identifying and treating psychiatric patients. Community Psychiatry has developed to the realization that much of the effort expended in the past as treatment for mentally ill individuals encouraged chronicity rather than a return to a productive life. Thus the current trend is to treat the individual immediately in the community, no matter how disturbed his behaviour may be.

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l Psychiatry: The study of mental disorder against ral backgrounds ï is an extension of cultural is both a theoretical and a practical discipline in which the psychiatrist and the patient have different cultural origins. Psychiatryôs horizons are ever widening ï from individuals to families, industries, communities, cultures, nations and the world knowledge of the one illuminates the many; problems and customs of the many impinge on the one.

(g) Social Psychiatry: It is a branch of study and research with important clinical applications that is concerned with the etiology, diagnosis, treatment and prevention of mental disorders. There has been great interest in the genesis and distribution of mental disorders in community population with emphasis on social, environment and psychologic variables ï as they affect the incidence and prevalence of mental disorders.

SELF ASSESSMENT EXERCISE

Highlight the benefits of adjustment to environment:

3.5 What is Psychiatric Nursing?

Psychiatric nursing is a specialized branch of nursing in which the nurse utilizes her own personality, her knowledge of psychiatric theory and the available environment to effect therapeutic changes in her patientsô thoughts, feelings and behaviour. Her ability to effect these changes varies according to her experience and education. The therapeutic role of the psychiatric nurse cannot be described only in terms of attitudes, feelings, relationship and understanding. What the nurse brings as a person to the treatment situation is directly related to her therapeutic effectiveness.

Psychiatric nursing is concerned with the promotion of mental health, prevention of mental disorder and the Nursing care of patients who suffer from mental disorder. Thus, psychiatric nursing is the process whereby the nurse assists persons, as individuals or in groups, in developing a more positive self-concept, a more harmonious pattern of interpersonal relationships and a more productive role in the society.

The goal of psychiatric nursing care is to encourage the patient to face reality and resume independent action as soon as possible. The psychiatric nurse assists in working towards this goal

(1) by his/her humanistic and understanding contacts with patients in his/her day-to-day activities,

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...e therapeutic team in establishing a

(3) by formally conducting psychotherapy with some patients.

The attainment of these goals results in the establishment of patterns of behaviour that is more satisfactory and satisfying to others.

Therefore, helping persons to accept themselves to improve their relationships with other people and to function independently are the most fundamental goals in psychiatric nursing. Psychiatric nursing provides opportunities for patients to change their maladaptive behaviour.

As a member of the ñTherapeutic teamò which includes the psychologist, social worker, occupational therapist, nurse and auxiliary workers, the nurse assists in formulating and implementing a broad plan of care for each patient to meet his total needs. This plan is developed after some contact with the patient so that all team members can share their observations and outline some of the patientôs most obvious needs.

Psychiatric Team

Whether a psychiatric patient is admitted into the hospital or treated as an out-patient, the modern method of care in both instances will be mainly ña team approachò. Thus:

(i) One or more Psychiatrists (Doctors) with a Consultant acting as a team leader

(ii) Ward or Unit Nursing Sister/Superintendent

(iii) Psychiatric Staff Nurses

(iv) Occupational Therapist

(v) Psychiatric Social Worker

(vi) Psychologist.

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ons of Psychiatry

Pre-Scientific

People believe that:

(i) Psychiatric illness is due to evil causes

(ii) Mal-evilment of others e.g. witchcraft

(iii) That mental illness is a form of maltoment e.g. taboos.

Negative Attitudes

(i) Discrimination against mentally ill people ï constituting popular jokes and mockery.

(ii) Rejection by family and society e.g. because of spoiling family name.

(iii) Rejection by society. He receives negative attitudes from colleagues on duty. Socially, he finds it difficult to mix with people; as people believe that they could also become psychiatric patient if they move freely with a mentally sick individual.

(iv) They are labeled by the public.

(v) Legal discrimination. Patients are kept in the asylum. They are compulsorily detained.

The whole procedure of asylum is like sentencing people who are mentally ill into imprisonment.

As a result of the negative attitudes of the public/society, mentally ill patients are regarded as patients who should be kept away from other people.

Another misconception is that because of the belief that mental illness has something to do with the appearance of ñmoonò ï hence the word ñlunaticò comes from the Latin word ñlunarò = moon.

4.0 CONCLUSION

Mental health is manifested in observable or covert behaviour. It deals with personal adjustment to the strains and stresses in oneôs

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ndles his problem as well as adjusts to
pe of personality a person has.

5.0 SUMMARY

In this unit, you have learnt basic concepts of this course. Note that mental health has been difficult to define because it is hard to pinpoint where mental health begins and where it ends as there is often an overlapping. Mental health is a relative quality of life. Life quality status is determined by how well a person is able to achieve the characteristics contained in the synthesized definitions and the quality of life in turn determine the level of mental health a person enjoys.

6.0 TUTOR-MARKED ASSIGNMENT

1. List the misconceptions of Psychiatry
2. What is the relevance of these misconceptions to the field of psychiatric nurse?

7.0 REFERENCES/FURTHER READING

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TAL HEALTH AND MENTAL ILLNESS
CEPTS

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1.0 INTRODUCTION

In the previous unit, we had looked into the meanings of the basic concepts in mental health and mental illness, this unit further continued the basic concepts as a better understanding of these concepts will serve as good foundation for the learners. This unit looks into the mental health system components and what mental health concepts contain.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- explain the concept of mental health
- discuss what mental illness is
- list and explain the mental health concepts.

3.0 MAIN CONTENT

3.1 Mental Health

The ability to cope with the recurrent stresses of living and achieve a relatively effective adjustment is referred to as mental maturity by many authorities, emotional maturity by others and mental health by some.

According to Mary Townsend in *Psychiatric/Mental Health Nursing,* ñMental Health is the successful adaptation to stressors from the internal and external environment, evidenced by thoughts, feelings and behaviours that are age-appropriate and congruent with local and cultural normsò.

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...nization defined Mental Health as ñthe ...f the whole personality. It can best be ...l disorder. The nurse is seeking to promote the mental health and happiness of her patients ï she needs to know what signs to interpret as evidence of mental health disorder. She must have a clear idea of the standards by which she can judge the behaviour of these patients and must know what to regard as normal.

A mentally healthy person has a realistic knowledge of himself and accepts himself with his strengths and weakness, can be genuinely concerned for others, can take care of himself without hurting others in the process and can tolerate stress and frustration.

Few people can be said to have achieved complete mental health or emotional maturity. Thus it is probably more helpful to evaluate the individual in terms of relative strengths or limitations in relation to the social norms and values existing in the community in which the individual lives. Mentally ill people demonstrate some strengths as well as limitation, it can be seen that the line of demarcation between mental health and mental illness is sometimes difficult to describe and is sharply defined in only a limited number of individuals. It also becomes clear that one can speak accurately of working with the healthy aspects of the personality.

3.2 Mental Illness

According to Townsend, Mental Illness is ñMaladaptive responses to stressors from the internal or external environment, evidenced by thoughts, feelings and behaviours that are incongruent with the local and cultural norms and interfere with the individualôs social, occupational or physical functioning.

Mental Health focuses on primary and secondary prevention of mental illness. Primary prevention involves the promotion of positive mental health and secondary prevention involves early diagnosis and treatment.

Mental illness is a complex problem. Early repetitive negative interpersonal relationship with the family situation apparently influences the future emotional health of an individual in many unfortunate ways. One of these ways is the lack of development of coping mechanisms that are adequate to meet the usual maturational and situational stressors of the society in which the individual lives.

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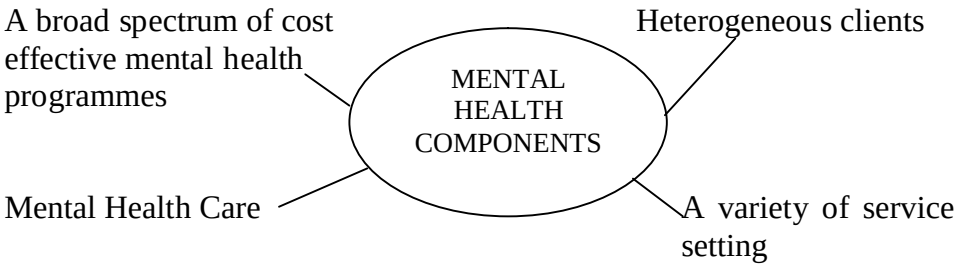
lth System Components

There are four components which are viewed as ñSubsystemsò of the Mental Health System. The Sub-systems are interdependent, since a change in one part affects the other parts, the four subsystems must be protected, nurtured and stimulated if they are to maintain a steady state or level of adaptation.



Each subsystem has specific functions and roles that must be maintained if the mental health system is to remain open to change and meet its goal of providing mental health care for clients.

3.4 Mental Health Concepts

óConceptô ï is general idea about something. We shall discuss briefly some of these concepts namely: Concept of Adjustment, Concept of Personality, Concept of Behaviour and Concept of Health

3.4.1 Concept of Adjustment

It is also referred to as the concept of adaptation or homeostasis. Adjustment can be defined as the series of techniques or process which the individual utilizes in order to meet the internal and external changes affecting him so as to maintain a state of equilibrium. Both internal and external changes often interweave and the individual tries to adjust to the problems simultaneously.

The internal changes could be in form of hunger, thirst, malfunction of an organ etc. Examples of external or environmental changes are increases or decreases in temperature, illumination, infections, absence of love and hostility.

Ability of the nurse to understand the process of adjustment will enable her help patients with their adjustment while planning for individual care.

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Personality is the total quality of an individual as revealed in his character habits, thoughts, experience, attitudes, interest, manner of actions and general outlooks. These attributes are relatively stable, for instance, if one knows a person well enough, he will be able to predict in a general form how the individual will react to a given situation.

The concept of personality is of great importance to the Nurse because it will enable her to understand herself and also understand her patients which will aid her in providing adequate care to participants.

Margaret Mead, world famous anthropologist, has written that mental health is actually determined by a set of ratios involving the emotional, social and psychological strengths with which an individual is fortified, the events he has experienced throughout life, the pressure he is currently undergoing and the expectations society has established for him.

3.4.3 Concepts of Behaviour

Behaviour refers to all activity of a person that is capable of observation by another person. It may be overt or covert. The concept of behaviour also involves the use of gestures and other non-verbal cues. Concept of behaviour will assist the Nurse to make important observations of both the patientsô verbal and non-verbal cues that will assist in providing adequate Nursing management.

SELF ASSESSMENT EXERCISE

1. Differentiate between overt and covert behaviour.
2. Give 2 examples of each.

3.4.4 Concept of Health

ôW.H.O. defines health as a state of complete physical, emotional/psychological, social wellbeing and not merely the absence of diseases.

Health is a relative term and there is no specific time on can say that an individual is in perfect health. ôW.H.O definition of Health is an ideal, an abstraction and more of a goal rather than something achieved. There is no set criteria with which to determine the state of health and there is no boundary between health and illness. Health and illness is in a continuum.

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In appraisal of Health status, it is necessary to consider the individualôs age and environment. With the knowledge of concept of Health, the Nurse will know that there is no set time at which illness stops and Health continues.

4.0 CONCLUSION

Mental health is the successful adaptation to stressors from the internal or external environment, evidenced by thoughts, feelings and behaviours that are age-appropriate and congruent with local and cultural norms. Now you will agree with me that mental health is not easy to define due to several intervening factors.

5.0 SUMMARY

In this unit, you have learnt various meanings of mental health and mental illness. We also attempted to look into mental health system components. The knowledge acquired in this unit should therefore aid an-in-depth understanding of the course.

6.0 TUTOR-MARKED ASSIGNMENT

1. List and explain the mental health concepts.
2. Why is it difficult to have a universal definition of mental health?

7.0 REFERENCES/FURTHER READING

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ES AND TRENDS OF CARE IN TH

CONTENTS

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1.0 INTRODUCTION

This unit will expose you to various challenges faced by psychiatric nurses in their day to day professional duties because of changes in patient care approach. A better understanding of these challenges will assist the nurse to meet the needs of the consumers of her service.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- identify some changes that affect the functions of psychiatric nurse
- list the psychiatric nursing skills
- explain the standards of mental health nursing
- discuss the general principles of psychiatric nursing
- mention the functions of a psychiatric nurse.

3.0 MAIN CONTENT

3.1 Current Issues and Trends in Nursing Care

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

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...es

- ...y (increased number of nuclear families)
- Increasing number of the elderly group.

Social Changes

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

Economic Changes

- Industrialization
- Urbanization
- Raised standard of living

Technological Changes

- Mass media
- Electronic systems
- Information Technology

Mental Health Care Changes

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

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

Educational Programmes for the Psychiatric Nurse

- Diploma in Psychiatric Nursing (The first programme was offered in 1956 at NIMHANS, Bangalore).

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...g (The first programme was offered in ...auri College of Nursing, New Delhi).

- M. Phil. In Psychiatric Nursing (1990, M. G. University, Kottayam).

- Doctorate in Psychiatric Nursing (offered at MAHE, Manipal; RAK College of Nursing, New Delhi; NIMHANS, Bangalore).

- Short-term training programmes for both the degree and diploma holders in nursing

Standards of Mental Health Nursing

These standards are a means for improving the quality care for mentally ill people. They were enunciated by the American Nurses Association (ANA) in 1973.

Development of Code of Ethics

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

Legal Aspects in Psychiatric Nursing

The practice of psychiatric nursing is influenced by law, particularly in its concern for the rights of patients and the quality of care they receive. The clientôs right to refuse a particular treatment, protection from confinement, intentional torts, informed consent, confidentiality and record keeping are a few legal issues in which the nurse has to participate and gain quality knowledge.

Promotion of research in mental health nursing

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

Cost-effective nursing care

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

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

New Trends in the Role of a Psychiatric Nurse

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

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

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

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

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

The number of nurses in the field of teaching psychiatric nursing needs to be enhanced. This is a big challenge for nursing curriculum planners.

Psychosocial Rehabilitation Nursing-It is concerned with helping people with chronic mental illness to lead more independent and satisfactory lives in the community.

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child psychiatric nursing the nurse
vioural problems of the children and

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

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

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

Neuropsychiatric Nursing-Psychiatric nursing practice is extended to patients who are suffering from neuro-psychiatric disorders such as dementia, epilepsy, brain tumour, head injury with behavioural problems, HIV infection with behavioural problems etc.

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

SELF ASSESSMENT EXERCISE 1

Outline some of the changes that affect nurses role in relation to Demographic and Technological changes.

3.2 Mental Health Nursing Skills

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

Prerequisites for a Mental Health Nurse

Personal Skills

Self-awareness-It is a key component of psychiatric nursing experience. It is an answer to the question, ñwho am Iò. The nurse must be able to

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elings, actions and reactions as a provider of care. A nd acceptance by the nurse allows acknowledging a and uniqueness.

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

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

Care values and attitudes

These includes:

- Self-awareness and self-esteem
- Respecting the personôs right
- Listening
- Responding with care and respect
- Supporting with trust and confidence
- Reassuring with explanation and honesty
- Physically nursing the helpless with compassion
- Carrying out procedures skillfully
- Working within personal and ethical boundaries

Counselling skills

These includes:

- Unconditional positive regard/non judgmental approach

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- Warmth and genuineness

- Confidentiality

- Non-verbal sensitivity, non-verbal attending, non-verbal responding

- Other interpersonal skills required are paraphrasing, reflecting, clarifying, summarizing.

Behavioural skills

These are based on Pavlovian principles and Skinnerôs principles. They include:

1. To increase adaptive behaviour

- Positive reinforcement
- Negative reinforcement
- Token economy

2. To decrease maladaptive behaviour

- Extinction
- Time out
- Restraining
- Over correction

3. To teach new behaviour

- Modeling
- Shaping
- Chaining
- Cueing

Supervisory skills

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

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

Teaching skills

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

3.3 Standards of Mental Health Nursing

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

Professional Practice Standards

Standard I: Theory

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

Standard II: Data Collection

The nurse continuously collects data that are comprehensive, accurate and systematic. Effective interviewing, behavioural observation, physical and mental health assessment enable the nurse to reach sound conclusions and plan appropriate interventions with the client.

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...osis and/or standard classification of mental disorders to express conclusions supported by recorded assessment data and current scientific premises.

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

Standard IV: Planning

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

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

Standard V: Intervention

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

(a) Psychotherapeutic interventions

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

(b) Health teaching

The nurse assists clients, families and groups to achieve satisfying and productive patterns of living through health teaching.

(c) Activities of daily living

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

(d) Somatic therapies

The nurse uses knowledge of somatic therapies and applies related clinical skills in working with clients.

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environment

structures and maintains a therapeutic environment in collaboration with the client and other health care providers.

Standard VI: Evaluation

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

Professional Performance Standards

Standard VII: Peer Review

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

Standard VIII: Interdisciplinary Collaboration

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

Standard IX: Utilization of Community Health Systems

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

Standard X: Research

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

3.4 General Principles of Psychiatric Nursing

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

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...y as He is

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

Acceptance is expressed in the following ways:

(a) Being Non-judgmental and Non-punitive

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

(b) Being Sincerely Interested in the Patient

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

This can be demonstrated by:

- Studying patientôs behaviour patterns
- Allowing him to make his own choices and decisions as much as possible
- Being aware of his likes and dislikes
- Being honest with him
- Taking time and energy to listen to what he is saying
- Avoiding sensitive subjects and issues.

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

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

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a Purpose

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

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

(e) Listening

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

(f) Permitting Patient to Express Strongly-Held Feelings

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

2. Use of Self-Understanding as a Therapeutic Tool

A psychiatric nurse should have a realistic self-concept and should be able to recognize oneôs own feelings, attitudes and responses. Her ability to be aware and to accept her own strengths and limitation should help her to see the strengths and limitations in other people too. Self-understanding helps her to be assertive in life situations without being aggressive and without feeling guilty.

3. Consistency is Used to Contribute to Patient's Security

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

4. Reassurance Should be Given in a Subtle and Acceptable Manner

Reassurance is building patientôs confidence. To give reassurance, the nurse needs to understand and analyze the situation as to how it appears to the patient. False reassurance can also reflect a lack of interest and

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...n the part of the nurse to empathize

5. Patient's Behaviour is Changed through Emotional Experience and Not by Rational Interpretation

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

6. Unnecessary Increase in Patient's Anxiety Should Be Avoided

The following approaches may increase the patientôs anxiety and should, therefore, be avoided:

- Showing nurseôs own anxiety
- Showing attention to the patientôs deficits
- Making the patient to face repeated failures
- Placing demands on patient which he obviously cannot meet
- Direct contradiction of patientôs psychotic ideas
- Passing sharp comments and showing indifference.

7. Objective Observation of Patient to Understand His Behaviour

Objectivity is an ability to evaluate exactly what the patient wants to sa y and not mix up oneôs own feelings, opinion or judgment. To be objective, the nurse should indulge in introspection and make sure that her own emotional needs do not take a precedence over patientôs needs.

8. Maintain Realistic Nurse-Patient Relationship

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

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...al and Verbal Force as Much as Possible

...shment must be avoided. If the nurse is an expert in predicting patient behaviour, she can mostly prevent an onset of undesirable behaviour.

10. Nursing Care is Centred on the Patient as a Person and Not on the Control of Symptoms

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

11. All Explanations of Procedures and Other Routines Are Given According to the Patient's Level of Understanding

The extent of explanation that can be given to a patient depends on his span of attention, level of anxiety and level of ability to decide. But explanation should never be withheld on the basis that psychiatric patients are not having any contact with reality or have no ability to understand.

12. Many Procedures Are Modified but Basic Principles Remain Unaltered

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

3.5 Functions of a Psychiatric Nurse

- Assessing the client and planning nursing care.
- Providing safe nursing care, including medication administration and participation in various therapies, individual interactions, formal and informal group situations, role-playing, advocating on behalf of the client, and so forth.
- Providing a safe environment, including protecting the client and others from injury.
- Accurately observing and documenting the clientôs behaviour.

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client based on observations of his

- Teaching the client and significant others.
- Involving the client and the clientôs significant others in the nursing process.
- Providing opportunities for the client to make his own decisions and to assume responsibility for his emotions and life.
- Cooperating with other professionals in various aspects of the clientôs care; thereby, facilitating an interdisciplinary approach to care.
- Continuing nursing education and the exploration of new ideas, theories and research.

4.0 CONCLUSION

Mental health nursing is the practice of promoting mental health as well as caring for people who have mental illness, potentiating their independency and restoring their dignity. No doubt for a mental health nurse to render qualitative service to the teeming populace, she must be skillful and knowledgeable in her area of specialty

5.0 SUMMARY

In this unit, you have gone through several current issues and trends in the care of the mentally disadvantaged individuals in the society. The skills she has to display and standards of care that must be maintained. We do hope you have learnt a great deal.

6.0 TUTOR-MARKED ASSIGNMENT

Why is the role of a psychiatric nurse in a pluralistic society like Nigeria?

7.0 REFERENCES/FURTHER READING

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RACTERISTICS OF MENTAL HEALTH

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1.0 INTRODUCTION

This unit will examine the characteristics of positive mental health, factors in the maintenance of emotional health and suggestions for improving positive mental health. We do hope that this unit will be helpful to you as learners for personal consumption and modification of behaviour to enhance a better living.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- list the characteristics of positive mental health
- discuss intelligently each of these characteristics
- describe the attributes of mental health
- critically examine yourself to see how many of the attributes mentioned above that you possess.

3.0 MAIN CONTENT

3.1 Characteristics of Mental Health

3.2 Characteristics of Positive Mental Health

Good mental/emotional health is characterized by:

1. The possession of the ability and capacity to keep ógoingô when life seems most uncertain, and a refusal to go into pieces in time of crisis;

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d not jumping into hasty conclusions cerned with directly or indirectly;

3. Making a thorough analysis of a given situation before embarking on any important action. A thoughtful and calculated action pays off better;

4. Displaying well founded self-confidence while being realistic about your limitations; being aware of your strong point when you formulate your plans and prepare to take advantage of your strength;

5. Avoiding excuses for not making genuine efforts that are calculated to put the ôother personô at fault;

6. Being able to learn from experience of others, for this saves you a considerable amount of time in the long-run;

7. Being able to sieve the important from the unimportant issues, so that you do not waste your time on the unimportant ones;

8. Desisting from any display of ôbig shotô behaviour which is an obvious manifestation of insecurity;

9. Facing real issues at stake and avoiding taking response in issues that have no relevance to what is at stake in an attempt to shift blame that is squarely yours.

While admitting the difficulty of setting up an exact standard by which an individualôs level of emotional health could be judged, Jones, Shainberg and Byer (1974) however set out a few characteristics which they consider the signs of good emotional health. But they also warn that lack of one or more of them in a person does not indicate emotional illness, because no one has all the traits of good emotional health at all times. They listed the following characteristics:

1. Ability to Deal Constructively with Reality

One of the signs of good emotional health is the acceptance of reality whether pleasant or otherwise. A person who accepts reality does not generally attempt to escape from reality by mental fantasy. According to Jones, Shainberg and Byer (1974), dealing constructively with reality means learning to acknowledge and accept oneôs own capabilities and limitations.

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apt to Changes

safety and security is largely responsible for the natural tendency to resist change. But a healthy person is confident of his ability to adapt to change because he realizes that the only thing permanent is change itself. He therefore expects change and plans ahead to adapt to it.

3. Ability to Make Long-Range Choices

Good emotional health requires giving up some immediate pleasures for the sake of long-term values. This is an important characteristic of a self-actualised person who has certain goals for the future and realizes he must make sacrifices for the moment in order to reach the long-term goals.

4. Reasonable Degree of Autonomy

The ability to function autonomously, to think for oneself and to make decisions and accept responsibility for the consequences are characteristics of good emotional health. Inability to make decisions for fear of mistakes is a sign of immaturity and insecurity. This characteristic does not completely rule out the need for dependence some time, for in our complex society we are depending on other people in many ways. Inter-dependency is also a sign of good emotional health.

5. Concern for Other People

An emotionally healthy person combines self-respect with a concern for the rights and happiness of other people. There is as much satisfaction in giving as in receiving. A healthy person readily accepts the differences he finds in other people and accepts them as they are.

6. Satisfactory Relationship with Other People

An establishment of satisfactory relationship with other people is closely related to concern for other people. A person who enjoys good emotional health is able to interact in a consistent manner with mutual satisfaction and happiness. He trusts most people and expects that people will equally like and trust him. He has lasting relationships with other people. He feels accepted as he makes others feel accepted.

7. The Ability to Love

A mentally/emotionally healthy person exudes love; not just the selfish love, but that which is unselfish. It is the emotionally rewarding

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eople. It is a love for humanity, which
ped sense of inner security can freely
express.

8. The Ability to Work Productively

One of the prime indicators of good emotional health is the ability to work effectively and productively. Conversely, inability to be productive may be a sign of mental/emotional illness.

3.3 Factors in the Maintenance of Emotional Health

Everyone is entitled to the satisfaction of his emotional health needs and at the same time, every person has needs to learn the effective emotional patterns of behaviour. A personôs physical as well as emotional stability depends not only on the satisfaction of basic emotional needs and learned pattern of behaviour but also effective maintenance of emotional health.

But the crucial question is ñhow does one know he is on the right track of emotional health?ò An attempt to answer this question has been done by Rice and Hein (1954) who pointed out that in spite of a lack of clear-cut rules; constructive suggestions could be made on which there is good general agreement. With these general agreements in mind as a basis for intelligent action, they contend that each person could condition his own behaviour so as to use his emotional energies to the best possible advantage. Such suggestions must be applied on an individual basis because of the individual differences. Emotional maturity, they further stated could be achieved only when each individual thinks and acts, which provide an effective adjustment to life, both for the immediate and for the future.

Rice and Hein (1954) have indicated the following as factors which characterize the maintenance of positive health:

Developing wholesome attitude to life

Developing interest in a variety of activities is an important step in the development of wholesome attitude to life. A student who devotes all his time on academic work or a gifted sportsman who spends all his time on the sports field or a social butterfly who spends all her time partying, cannot be said to be developing a wholesome attitude to life.
Having a wholesome attitude also involves a thorough analysis of problems with an open and objective mind. It is important to study how others have solved problems, to make tentative plans on how to solve your own problems, to try out the plans while checking the results

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d also be aware of the possibility of failure in order isappointed or discouraged when the first attempt ccess.

Building emotional stability

Everyone is constantly faced with situations which arouse very strong emotions which are often bottled up. Such a situation may lead to very serious physiological and psychological consequences. Seeking a positive diversion has been suggested as a worthwhile solution. Such suggestions include participation in vigorous physical activities, unburdening yourself to a trusted friend, a relation or a leader of your religious group. A sympathetic listener can do a world of good in reducing personal conflicts and pent up emotions. When you can talk freely about your problems to a willing listener, some of the emotional tensions which were previously stored within you will be given an outlet. Fears, anxiety, failures and anger often detract from emotional stability. Failure is not always bad; same as stress, but like uncontrolled stress, if you allow a failure to lead to insecurity and fear of possible failure, or allow failure to weigh you down, the effects can lead to disequilibrium of your emotional stability.

Learning to face reality

It has earlier been pointed out that one of manôs greatest problems is his inability to analyze his actions objectively. But with concerted effort, one can improve his ability to appraise his own reactions objectively. Man is constantly using such defence devices as rationalization and projection, in an attempt to escape from reality. But if you appreciate the fact that these devices are only a means of escaping from reality and that when you carry them to excess, you may be heading for more serious problems, you are more likely to face any problem confronting you realistically. The realization of the importance of self-acceptance and the universality of imperfection should make it easier to accept or admit oneôs mistakes, accept the consequences of oneôs actions, to rectify the error when this is possible or attempt to handle i.e. the next situation in a more satisfactory way. Lifeôs problems seem unending. You should not only look at them objectively, but also be realistic in your approach to solving them. Falling back to unrealistic self-defence devices or giving way to emotional outbursts is clearly a sign of emotional immaturity or poor emotional health.

Setting suitable or realistic goals

Ability to set goals to be achieved in whatever one does is a mark of good mental health. Such goals may be set for a day, a week, a month or

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the person works to accomplish the impact of goal setting on emotional ...stantly evaluate your strong and weak points objectively and carefully in order to ensure the successful achievement of your set goal or target.

If you set goals which are not consistent with your personal capacity, you will find that the effort will be lost and this may lead to serious emotional problems, the cause of which may not be apparent to you.

Working for achievement

Nothing is more motivating or stimulating as success. Success is a major ingredient to emotional and mental health. Working for achievement is closely related to setting up realistic goals. Real joy in success comes when the success is the result of hard work. Success which is derived with little or no effort does not give the kind of satisfaction which success derived after a persistent hard work gives.

It is therefore important that, for you to have the real feeling or a sense of satisfaction and achievement, you must set the goals which are not only realistic but that which also demands reasonable amount of hard and persistent work with a few risks along the way.

Improving skills in human interactions

There are only a few activities which individuals carry out in solitude. This means there are a great many activities in which a person has to interact with other persons. It is therefore essential that whether in work or play, you learn to get along with other persons. Once you can do this you will be achieving one of the benefits of mental health. Group activities in which people share fellowship satisfy the basic human need of belonging as well as present opportunities for the achievement of new experiences. Effective human interactions require that the individual submerges his personal importance, except when this is used to enhance group effectiveness. The establishment of a close friendship with someone has special mental health values, especially when the friendship is founded on the basis of give and take. When this happens, there is free communication and sharing of ideas, and an attempt to solve each others problems.

In order to sustain friendship or remain a valuable member of a group, skills in human relations must come from sharing what you have more than waiting to always receiver. True friendship means willingness to accept and respect confidences, as well as to discuss your problems, to listen sympathetically, to forgive the frailties of your friend(s).

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ship with this type of open-mindedness has a it contributes to the mental and emotional health of cing this mutual friendship.

Accepting limitations

An awareness of oneôs limitations is an important step towards maintaining emotional health. A personôs health status is determined by his physical, mental and social health status. Being aware of oneôs physical limitations helps one to adjust to such limitations while maximizing potentials in certain areas of accomplishment where the effects of his limitations are minimal of completely absent.

A physical cripple may become a mental cripple or may develop resourcefulness to compensate mentally for his physical disability. A blind or deaf and dumb person may feel hopeless and helpless and dependent on other persons for everything or may become a Helen Keller who in spite of her blindness became a celebrity with her inspirational verses on greeting cards. There are several examples of persons who in spite of their physical handicaps or limitations have achieved fame and success, because they accepted their limitations and compensated for them in other meaningful and satisfying ways. There are also thousands of others who have become almost neurotic over slight physical deviations such as being a few inches taller or shorter than their expectations and wish. In the final analysis, what is important is not the physical conditions which one has, but the reactions to them. It is this which constitutes an important in a personôs mental health.

Ability to seek for professional help

Family members, trusted friends and ministers of oneôs religious faith have earlier been suggested as persons who can be taken into confidence in the event of problems that might be impinging on an individualôs mental health. Outside these persons are those who are professionally trained to handle the different levels of mental/emotional health problems. These are guidance counselors, psychiatric nurses, social health workers, psychologists and psychiatrists. Even the psychiatrist whose main concern is the treatment of serious mental cases, have now directed that efforts should be made to take preventive measures against mental and emotional illness. Seeking help for mental and emotional health problems seem to have a social stigma in Nigeria, as elsewhere. But this should not be and should be regarded as any other illness. Since people now have less time for one another in this country, which is most unfortunate, it is necessary that a troubled person should seek out professional help before things get out of hand. The fact that a person sees a psychologist or psychiatrist does not necessarily make the person

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is aware he has problems, the nature eds professional assistance to help him d how to cope with the problems and how to avoid any future occurrence.

3.4 Suggestions for Improving Positive Mental Health

There is no doubt that both individuals and the society have roles to play in improving the mental health of the people.

Individuals should:

a) be well educated and understand the essence of positive Mental Health.

b) abstain from use of dangerous drugs.

c) avoid religious fanatism.

d) try to show understanding in terrifying issues and approach same maturely.

e) donate generously (i.e. wealthy individuals) to assist or complement governmentôs efforts in the funding of Healthcare.

Government should try to:

a) provide adequate hospitals, health workers, drugs and materials

b) health ï educate the populace via the use of radio, television, postals, organize symposium and seminars

c) provide employment and security for people

d) adequate funding of the total health care industry.

4.0 CONCLUSION

Positive mental health is characterized by keeping emotions under control, being flexible to change and good reasons, being able to bounce back to normal life fast after a period of crisis, being open-minded, having self-confidence, accepting responsibility for oneôs actions, ability to learn from experience, ability to discriminate between important and unimportant issues, dealing constructively with reality, being adaptive to change, having autonomy, being able to make long-range choices,

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for others, establishing good inter-personal to love and ability to work independently.

5.0 SUMMARY

In this unit, we have learnt about the ability to adapt to changes, characteristics of positive mental health, factors in the maintenance of emotional health and suggestions for improving positive mental health.

6.0 TUTOR-MARKED ASSIGNMENT

How can an individual promote positive mental health habits?

7.0 REFERENCES/FURTHER READING

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CTING MENTAL HEALTH

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1.0 INTRODUCTION

In the previous unit, we have examined positive mental health, no doubt it was an opportunity for self-examination of each learner and the need for behavioural modification. This unit will afford the learners to explore factors affecting mental health as mental health is affected by a variety of factors, and it is a product of the interactions between these factors.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- identify the factors that affect mental health
- discuss the importance of each of these factors
- relate each factor to your own mental health status
- explain the role of genes in mental health.

3.0 MAIN CONTENT

3.1 Factors Affecting Mental Health

3.2 Mental Health Factors

The determinants of mental health include a personôs total make-up as well as a biological organism, the influences of the society into which he is born, and the interaction process between him and his society, experiences by which he influences other persons as well as the ways in which he is influenced by others. Specifically the factors which affect mental health are essentially hereditary factors and environmental

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tal factors are the physical environment, social and
nment.

Hereditary as factor in mental health

Hereditary is the force which provides the raw materials and the potentials for every individual. It is thought that hereditary also sets the limits to a personôs mental health in some respects, but the exact role or function has not been fully identified. From a psychological viewpoint, hereditary as a factor is of some importance. For instance, the potentialities for intelligence (IQ) of a person are present at birth, and are, in the absence of environmental factors, determined principally by hereditary factors. It is known that the various strengths and weaknesses of physiological systems which a person possesses are present at birth. It is also known that there is a constitutional predisposition towards a certain degree of activity. For instance, some children are much more aggressively active from birth than other children, without a demonstrable reason to be found in the environment for this. Hereditary does not completely seal adpersonôs fate as it is sometimes thought, but it certainly provides a conditioning for who a person is but its effects can be modified or adapted to allow the person concerned to enjoy maximum mental health within his limitations.

Gene and hereditary

It is known that traits or characteristics are transmitted from parents to offspring through the genes. Genes are materials which determine a personôs hereditary endowment. There are many and varied types of genes, each of which bestows a certain characteristic or trait. Some genes are dominant and others recessive. Each gene works differently and in combination, the effect is also different. Also, the factor of the cell environment including its chemical composition and the mutation within the cell produce their own different effect. The genes replicate themselves along with cell division. Each cell thus has the same hereditary materials as the original fertilized egg. The gene provides a personôs functional potentials such as growth, appearance, personality and intelligence mentioned earlier as well as other qualities which make one person unique from others. Intellectually, genes lay down the capacity for thinking, but how well this capacity is utilized or developed depends to a large extent upon environmental experiences.

Genes and physical appearance

The part played by heredity is probably clearer for physical than for mental traits. There is no doubt that a personôs physical features such as size (slenderness; stockiness) and shape are closely determined by his

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...e for size for instance can either be ...by the kind of environment one is born ... tremendous modifying influence on hereditary. Todayôs children are by and large, bigger and taller than their peer of about twenty-five to thirty years ago because of better feeding, better medical care and better conditions among others. These are clearly examples of the effects of environment on hereditary.

Gene and genetic disease

Some health conditions such as sickle cell disease and haemophilia are genetic diseases because they are inherited. These are blood disease often termed molecular diseases, due to the change in the molecular structure of the haemoglobin in the blood cell. Haemoglobin is the substance in the red blood cell which makes it possible for the cells to carry oxygen to all the working muscles of the body and the brain.

In the sickle cell disease, the sickle-shaped cells cannot move freely through many of the small blood vessels, consequently the cells tend to pile up, causing blood clots which block the flow of blood to the tissues. In addition, the sickle cells are destroyed by natural processes more quickly than normal cells. In haemophilia, there is tendency to bleed profusely from even a light injury and the victim can bleed to death if unattended to quickly by an expert.

These genetic diseases create a tremendous amount of psychological stress to the victims and their families and this in turn affects their mental as well as their physical health status.

Physical environment factors which affect mental health

Physical environmental factors contribute significantly to the mental health status a person possesses. The development of a wholesome and pleasing personality resulting in a well-adjusted individual depends on this foundation of physical health. An erect posture, a winning smile and a feeling of exhilaration ï all promote a sense of personal security. Strength, good physique, good looks and robust health ï all provide a social advantage in the development of personality characteristics. All these have a salutary effect on a personôs mental health.

A feeling of physical well-being engenders intellectual alertness, enthusiasm, a disposition and a desire to live, to achieve and to be happy. Not all individuals who are in good health have positive mental health. However in most cases, the better the physical health, so also will be the mental health. There is evidence that mental health is improved by physical health. A body in disease thinks nothing but how

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ase, so the stress created by this condition definitely
h.

Mental health is affected when one is physically tired from conditions such as hunger, over-work, or when one has had loss of sleep or one is under extreme heat or cold. Sick persons, particularly the chronically ill has much has much harder time coping with life. Studies have shown that vitamin diseases for instance lead to poor health and consequently personality problems. For example, vitamin B deficiency results in restlessness, anxiety and cruelsome disposition. Pernicious anaemia (a deficiency of the red blood corpuscles) produces characteristic symptoms of apathy, irritability and anxiety. The origin of these mental health manifestations are physical factors.

A person who has very serious physical defects tends to have some similar problems as above, although there are exceptions. On the other hand, a person who follows a balanced regimen of food, drink, physical activity and sleep, rest, relaxation, disease prevention, personal hygiene is most likely to enjoy a high level of physical health which will in turn elevate his mental health.

Social environment factors which affect mental health

In the discussion of heredity as a factor in mental health, we touched on environment several times. Social factors constitute a personôs environment. The environment compasses the society in which a person lives, the people within the society, the interaction process and functioning within society. Of significant importance to a person in a social environment is his ability to cope with social situations as well as with other persons as he participates in his everyday activities. These social interactions and activities within a personôs environment have a tremendous impact on his mental health.

As a personôs personality emerges, it is modified by the environment through the influence of parents, peers, teachers, administrators, government, employers, co-workers as well as the existing social systems. Cultural beliefs and norms also help to mould the personality of its members. A social system can be progressive and thoughtful with regards to the comfort of its members by providing health and social services, establishing industries and executing programmes needed for desirable changes in the society. A healthy social system is one that calls for not only a better understanding of opportunities to improve social patterns but development and implementations of effective plans to alleviate human frustrations and bring about better social change. The ultimate goal of mental health is a social one; to help every person to live a more effective life.

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unit of the society and no other unit meets the basic human needs more directly than the home. The family provides the setting for emotional stimulation and support as well as the guidance that enables the child and every of its members to cope successfully and therefore, to maintain mental health. The home does this by showing genuine affection for each of its members and establishing harmonious relationships between family members.

Mental health and the school

The school is the next socializing institution where individuals develop sound mental health practices. The school environment could also adversely influence mental health of the children. The school is expected to provide experiences which lead to the development of the total individual through self-realisation, human relationships, economic efficiency and civic responsibility.

School experiences are expected to enhance growth and development, stimulate learning and develop good behaviour patterns. Every school programme is expected to be planned and executed so as to assist children to satisfy their basic needs of love, acceptance, security, independence and self-control. This will in turn add to the mental health status of the children.

Specific areas in the school setting which influence the childrenôs mental health are the physical environment exemplified by the school site and building and the emotional and social environments. A good school plan must consider the site of the school, ventilation and lighting in the building, spaciousness of the classrooms to avoid over-crowding, good acoustics, water supply, good waste disposal facilities as well as other facilities for maximum comfort. A good site should also be free from incessant noise and from unnecessary intruders.

A school with good emotional climate should have consideration for the length of the school days, workload for children, amount of homework, class grouping and grading system. The social climate should take cognizance of the inter-personal relationship between students and teachers, students and students and among the teachers. A school that rates high in the above provisions is well on the way to providing opportunities for high level mental health for its pupils. This will not only enhance their general well-being but also ensure maximum learning. As a result of the importance of the school in the mental health of the school children.

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NT EXERCISE

Discuss with your colleagues some of the factors discussed under mental health in the school and at home.

Mental health and the community

The community provides the environment in which a person achieves his social status and in which his family lives and grow. Family members develop individually not only through interpersonal relations with one another but also through participation in community activities. A community can influence the personality development of its members positively or adversely. On the other hand, a community that ensures security of every member, provides adequate jobs for high percentage of workable adults, adequate housing, shops or markets where one can buy what he/she needs, sufficient basic amenities ï water, roads, electricity etc. and a sense of belongingness is definitely making a concerted effort to promote the mental health of its members. What is your assessment of your community?

4.0 CONCLUSION

Mental health like general health is affected by a variety of factors and it is a product of the interactions between these factors. The interplay of heredity and other factors within the human environment contribute to the mental status of a person.

5.0 SUMMARY

An enjoyment of a high level of mental health requires an endowment of good genetic inheritance and freedom from any of the genetic diseases and enjoyment of a high level of physical health by observing the roles of personal health and freedom from any serious physical defects and ability to interact positively with people in the home, school/workplace and within the community. Stress is the foremost factor in the environment that affects mental health.

6.0 TUTOR-MARKED ASSIGNMENT

Explain the specific roles of genes in mental health.

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Unit 1 Healthy Mental Health Environment
Unit 2 Sources of Mental Health Problems in the Youths
Unit 3 Coping Devices and Defence Mechanisms
Unit 4 Causes of Mental Illness
Unit 5 General signs and Symptoms of Psychiatric Disorders

UNIT 1 HEALTHY MENTAL HEALTH ENVIRONMENT

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1.0 INTRODUCTION

The last unit was on factors affecting mental health where several factors were looked into. This unit will take you through healthy mental health environments.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- examine the impact of the home front on the mental health of individual members of the family
- state how a childôs school environment can either make or mar his mental health
- explain how a personôs working environment can affect his mental health.

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3.1 Healthy Mental Health Environments

There are three settings which provide for a healthy mental health environment, namely, the home, the school for students and the workplace or place where one earns a living for the adult worker. For the purpose of this discuss, the school age child or adolescent not in school for economic or any other reasons and who engages in activities directed towards earning a living is considered a worker. The student spends a good part of his time in the house and in the school, while those not in schools such as adults and drop-outs also spend most of their time at home and at the place they earn a living. Time spent in other places within the community is usually less than time spent in any of the above primary settings.

We are going to consider factors within each of these settings which can either positively or adversely affect the mental health status of an individual of whatever age, sex or social status. We have previously classified environment into physical, mental and social environment. The emphasis in this unit is on mental/emotional health environment, we must not loose sight of the fact that the various forms of environment influences one another The type of atmosphere generated by either physical or social environment influences an individualôs mental/emotional environment.

3.2 Mental Health Environment At Home

The concept of home connotes a place where a father, mother and siblings reside. This is a place where they all converge after each has returned from the dayôs activities outside the home. A home is a place where the inmates interact as members of the same family. In a restricted sense, the home is a place where a mother and a father are present except where the absence of one is either temporary and by mutual understanding as in the case of transfer, study leaves, short trips or by the demise of one of the spouses. Even under a death situation, the home could not be considered complete because each member has a role to play. It is not an easy task to attempt to play the role of both father and mother to siblings successfully by a single parent.

Influence of home environment on a child's mental health development

In order to ensure that a child grows in a healthy environment, there has always been a need to move a child who has suffered the death of one of

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e where he can live in an environment that promotes and social growth, but also mental growth.

A home is a fortress to which a child can always for sympathy, protection, love security, food, understanding and acceptance. A home that a child can look up to, for the satisfaction of the basic needs, such as those enumerated above constitute an environment which engenders good mental health. By contrast, a home torn by strife, quarrel, fighting, swearing and a home where there is constant hunger, fighting, lack of care, lack of love and security, lack of understanding, etc. constitutes an environment which generates frustration, fear, insecurity, delinquency and anti-social behaviours in a growing child.

A conducive emotional home environment for the child is one in which parents not only provide the childôs basic needs but also discipline and guidance. While over-strictness can generate negative feelings in the child, over-permissiveness is equally dangerous. Parents must provide appropriate balance between being very harsh or over-permissive.

A growing child needs independence and freedom, but he needs also guidance in order to use his freedom and independence with great responsibility. A child needs friendship of his parents, to share the day adventures, to seek opinion and advice and to communicate. Parents should therefore make themselves available for family interactive sessions often. An environment that makes it possible for children to talk freely, but with respect to their parents will promote good mental health.

Importance of health home environment to parents

It is not only the siblings that need a wholesome mental environment. The behaviour of the adult members of the family towards one another not only influences/affects their attitude to their children, but also to themselves. A wholesome home environment has a positive influence on adult mental health and an unfavorable environment generates mental emotional distress.

There are many factors which can influence the behaviour of a husband towards the wife and vice versa. The way these factors are managed often determines the kind of relationship that may exist between them. We shall examine two of these factors and you should think of numerous others. The two singled out in this lecture ï money and sex issues ï are considered the foremost issues which have caused untold disasters in matrimonial relationships.

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aintenance of wholesome home

Traditionally, the man is considered the breadwinner. He is expected to provide money for family sustenance. Even though in these austere days, when it has become expedient more than ever before for the woman to take on some job either to fulfill her professional goal or to supplement family income, the man is still expected to carry the bulk of the family sustenance bill. Where this responsibility is not being carried out, it is the danger signal especially if the woman is incapable of making substantial contribution to family income.

This danger becomes even more serious if the woman believes the man makes enough money but fails to provide sufficient amount to feed the family. As a result, the woman naturally nags. She complains even in the presence of the children and inadvertently drops the hints that their father has failed in his duty and therefore useless. The inevitable follow-up of abuses, quarrelling and even fighting thus creates poor emotional health environment for everyone in the home. The couple may now be cohabiting rather than really living together as a family. Love and respect is lost for one another.

They may begin to seek outside ways to compensate for what is lacking in the home, ï love, caring, understanding, fellowship etc. The situation ultimately gets into a chain of reactions which boomerangs on the entire family. The woman begins to find other means of finding money to feed herself and the children, then the man begins to stay out more and more seeking comfort in other women and/or outside interest. The final thing there may be the complete breakdown of communication in the family, with the woman leaving home or being kicked out and the children dangling in-between.

On the other hand, a positive environment for good mental health is created when the breadwinner gives out money regularly and both the breadwinner and housekeeper sit down to discuss their problems and agree on how they can jointly tackle them. Even where very little money is coming to the woman for food and housekeeping bills, with love, understanding, communication and friendship, the family can remain cohesive. Most women do not mind making substantial contribution to providing family sustenance needs as long as the breadwinner does not completely abrogate his responsibility to the family. Women are generally proud and respectful of husbands who can accept their responsibility to the family. Situations in which a woman is proud of the husband and respects him; in which there is harmonious relationship, creates an environment for positive mental health growth and the

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bibe those attributes of their parents which have harmoniously.

Influence of sexual relationship on healthy home environment

By nature, the males sexual feelings are more easily aroused although it is known that some women are highly strong sexually, but these seem far and between, when compared with men. A man reaches his state of readiness for sexual act several minutes ahead of the woman. The woman must therefore be led on gradually to the level where she is physiologically and psychologically prepared for sexual intercourse. If a woman is compelled to have sexual intercourse when she is not physiologically and psychologically ready, she is left in a state of mental and physical torture long after the man has attained the ecstasy of the act and is soundly asleep.

When this woman is constantly compelled to have sexual intercourse when she is not ready, she gradually becomes frigid or physically resists having any intercourse that will end up leaving her unsatisfied and sleepless every night the experience takes place. For a violent husband who will always want to satisfy his sexual urge, every night creates fear for the woman. This type of situation affects the mental health of the woman adversely and this could manifest itself physically and socially, especially if the woman then seeks for sexual satisfaction outside the matrimonial home.

A woman has sexual feelings and needs to satisfy these feelings as much as the man does. But her physiological make-up must be understood and appropriate allowance made for this by the man. The act of sexual intercourse must begin several hours before he actual act with loving words, appreciation of what the woman has done during the day, intimate conversation about the dayôs ógoings and comingsô, sharing individual activities of the day. Then while in bed, the tender feelings continue to set the foreplay until the woman is gradually led to a point where she is ready for the sexual act. The man has to learn to hold himself until the woman is ready. Once the habit of helping the woman to reach a level at which both arrive at the plateau of the act at the same time or very close to each other, is established, the woman looks forward to having sex rather than being afraid; and rather than being frigid in bed, she would participate actively in the act of making it pleasurable for the man as she herself enjoys it.

Another point of importance is that of lack of consideration for the physical state of a woman. Being a mother, worker and home-maker, she is often tired at the end of the day. When this happens, all she needs is a good rest and sleep. A husband must realize this need and respect it,

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exual relationship. A tired body can iciently in anything including sexual

An important point about sexual relationship is that both husband and wife must have consideration for the needs and feelings for each other. No one should deny the other sex, and at the same time, no one should compel the other to have sex when one of the partners is not in the mood. The decision to have sexual intercourse should be mutual. It is the constant lack of consideration for each otherôs needs and feelings that creates an unwholesome home environment. A healthy home environment is a pre-requisite for a happy matrimonial home.

3.3 Influence of School Environment on a Child's Mental Health

An important component of the school health programme is the provision of healthful school living environment, which embraces all the efforts made to provide at school physical, emotional/mental and social conditions which are beneficial to the health and safety of students. While the importance of maintaining a healthful physical environment is acknowledged, the major concern here is the promotion or otherwise of healthy social and emotional environment. The tone of the school can have either positive or adverse effects on studentsô desire to learn and to identify themselves with their institution.

Tragedy of unwholesome school environment

The tragedy of unhealthy emotional environment generated by the school is not that studentsô performance is most likely to be poor but that the impact is likely to lead to anti-social behaviour such as delinquency, lack of respect for constituted authority, destruction of public or private properties, frustration, aggression and such behaviors. School authorities, administrators and other school personnel must be aware of the implications in a situation where an institution at whatever level of learning does not provide a healthy mental health environment.

Students are happy when they have an attractive school and when the school is well organized. They are happy to be in school where everyone is treated with respect and dignity; they are happy when the teachers can be relied upon and are fair in all their interactions with students. Beautiful scenery, clean and orderly environment, contributes to healthy emotional well-being. The inescapable conclusion is that students who attend institutions that provide healthy mental health environments are more likely to do much better than their peers who attend institutions that do not provide conducive teaching-learning environment.

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f Workplace Environment on Mental Health

The joy a person derives from his workplace or a place he earns his living depends largely on the type of atmosphere that exists in the place. Such an atmosphere naturally affects the mental health status of the person. There are factors which determine the kind of mental health environment a workplace possesses. These include job satisfaction, job security, promotion or advancement prospects, job schedules, inter-personal relationship etc. The kind of environment generated by the above factors is directly related to whether or not the worker is having a good or bad time in the workplace.

Job satisfaction and mental health

A job that gives satisfaction promotes good mental health. To some people, their job is drudgery and they derive no joy in what they are doing, but they work just to live. For some persons, they work on monotonous schedules, doing the same thing day in day out sometimes without thought. They are simply robots. In contrast, a job that is challenging and meaningful to the worker generates a healthy emotional environment which leads to job satisfaction. A job that offers workers opportunities for initiatives, for constructive idea and for experimentation founded on well thought out hypothesis creates an environment which is mentally stimulating and challenging and emotionally satisfying.

Job security and mental health

Initially a person without a job will grab on anything that comes his way. But later he begins to think of the job security. Unless he is assured of job security, he becomes almost as insecure as he was when he had no job. The uncertainty of job security creates fear and apprehension both of which detract from mental health. Even when tenure of job has been established, constant harassment from superior officers can also create job insecurity with the attendant mental health consequences.

Job prospects and mental health

Advancement in oneôs job means more money or pay. It does not matter how long it takes one to advance from one stage to the other, but there is that satisfaction so long as the criteria for advancement is clearly outlined and that there is justice and fairness in the interpretation of the guidelines. Lack of job prospects and advancements generates a climate which dampens the spirit of workers and this leads to low productivity. More importantly, it kills morale and reduces mental health status.

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...ionships on mental health

...ement and workers, between workers and their immediate supervisors or among workers themselves goes a long way to determine the mental health disposition of workers while at work. A cordial and friendly relationship creates a most congenial climate which in its wake promotes positive mental health. Workersô morale is improved by discussion groups and case conferences on matters relating to the working conditions in the organization.

4.0 CONCLUSION

Indeed, there exist a delicate relationship between mental health and the environment of man. Observations have shown that the more the environment of man stimulating the more mental health is enhanced and vice versa.

5.0 SUMMARY

We have examined conditions which can promote positive mental health environment at home. For a child to grow and develop well, he must be provided with the basic human needs, namely food, shelter, clothing, security, love and affection. He needs self-esteem and a sense of belonging. All these will generate in an atmosphere in which the child can grow and develop optimally. For the two principal adults in the home (father and mother, husband and wife), understanding, cooperation, love and affection, sharing and faithfulness and carrying out individual responsibilities creates an environment which promotes positive mental health at home.

Healthy mental environment in the school leads to effective teaching and learning process. A good school setting in terms of excellence in academics and sports, good organization of school programmes, good inter-personal relationship between teachers and students which engenders mutual trust and respect culminate in providing conducive mental health environment in which to teach and learn.

6.0 TUTOR-MARKED ASSIGNMENT

Interactions between environment and mental health is crucial to man. Discuss.

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IENTAL HEALTH PROBLEMS
S

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1.0 INTRODUCTION

In our previous units, we examined factors which affect mental health and identified them as heredity and environment. The home, school and community were also considered as places where individuals including youths interact with significant others with consequent influence on their social and emotional health. This unit will examine some of the sources of mental and social health problems of youths in our society.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- explain why some youths give up family relationships
- show how inability to adjust socially and emotionally impinges on the mental health of youths
- explain how an unwholesome social and emotional climate at school can affect the mental health of youths
- list the causes of loneliness and the consequences to mental health of the youth.

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TENT

3.1 Common Mental Health Problems of Youths

Youths are generally classified as those who are in the senior secondary schools and in the tertiary institutions (colleges of education, polytechnics and universities) and other similar institutions. Age-wise, this period can be placed between fifteen or earlier to perhaps thirty. For this lecture, youths under consideration are not limited to only those who are schooling. They include also those not only in schools but are within the studentôs age range. Students and other youths are confronted by a considerable number of social and economic problems which impinge on their mental health. It is not possible to discuss or examine the gamut of mental health problems which confront young persons. Attempts have been made in this lecture to discuss briefly some of these problems which have been highlighted by John, Sutton and Cooley (1957) and Bryd (1957). Some may appear very trivial, but you should be aware of the fact that the seriousness or the triviality of a problem depends largely on the capacity of an affected youth or a person concerned to cope with the situation. These problems are by no means exhaustive. They include:

3.2 Inability to Give Up Home and Family Relationships

Every person is expected to develop some emotional attachment to his family and home ï to think of the home and family members with love and affection, to want to meet with the members as often as it is possible and to interact meaningfully and happily with them. All these feelings are products of how the family, as an institution has been held together and sustained. Unfortunately however, some families bring up their children in such a way that they are not helped to be independent outside the family. They do not encourage the children to move out and interact with their peer while growing up. The children are over-protected to the point that they become docile. Such children grow up without learning that life exists outside the home and the world could be very rough and trying and that it is only the tough that keeps going when the going gets tough.

Lack of encouragement to children to explore the world comes from over protectiveness creating situations which ultimately affect the childrenôs mental health. Not being prepared for the world outside the home, they meet with so much frustration which generates stress. Their only solution is to constantly fall back to their home ï a kind of defence mechanism employed to avoid facing reality. Inability to face the realities of life outside the home or to adjust and find a satisfactory way

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ychological and mental problems such
health development.

3.3 Rejection of Parental and Home Standards

We have examined the case of some youths who by their upbringing are unprepared for independent existences outside the home and therefore cling to the home whenever they are threatened or confronted with any type of problems. There are however other youths who may have been over-protected and/or over-restricted and who therefore, cannot wait to leave home in order to gain freedom to do things their own way. The moment they move out of their homes, they tend to renounce parental and home standards. Deep down, parental love and affection is still there, but the young adult refuses to accept the standard of the parents. He may in fact be confronted with two or more different standards ï standards within the home and those outside the home environment. The youth thus passes through a period of decision-making: ñWhich standards do I adopt, the home or the outside standards?ò During this period of decision-making, which is also the period of conflict for the youth, he goes through a period of stress which may be short-lived or long-lasting, depending on which way he resolves the conflict. More often than not, the youth takes the opposite end from the home situation. The fact of the issue at hand is that the rejection of familiar situations creates a wedge in the relationship of parent and the youth and this must occasionally generate some stresses, for the youth is torn between his love and affection for his parents, and rejection of their standards. This situation thus impinges on the mental health of the youth.

3.4 The Search for Identity and a Purpose in Life

Parents can give their children protection, security as well as attend to their other physiological needs. They can give them a sense of belonging: they may sometimes attempt to give them identity by letting their own names, success and reputation rub off on them. But these are often times borrowed garments that may wear out with time. The real identity must be found, discovered and/or built for oneself. Coupled with the discovery of oneôs own identity is also the discovery of oneôs purpose in life.

The search for identity and purpose in life goes beyond the emotional and social dimensions of humans. It operates on the non-physical level; i.e on the spiritual and psychic level. The search may be enhanced by oneôs upbringing simply by familiar modeling, or the youth may be left to grope in darkness until he finds something he can hang unto. Although there are a variety of reasons why youths in the secondary and tertiary institutions join the many religious sects in their campuses, the

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fact be that many of them go into these ventures in r themselves the meaning of their existence and the purpose of their living. Believing that they have found what they are searching for, some of them become fanatical, while others balance their belief with reality. Some never succeed in finding solutions to the question bugging their minds: Who am I? While this search and discovery lasts, the youthôs mental health status is deeply involved.

3.5 Lack of Social and Emotional Adjustment

Inability of some youths to adjust to social and emotional situation when they step into the wider world reflects on the social interaction and emotional climate in the home. Feelings of superiority and/or inferiority are both manifestations of lack of social adjustment. Youths from more affluent homes which believe that their affluence gives them a right over every other person, naturally grow up to see themselves as special beings. Such persons lack humility and consequently do not find it easy to interact with other persons except those who are willing to accept inferior positions to them. In the same manner, some youths from the less affluent homes in which the family members are content to accept anything that comes to them are more likely to accept inferior positions in their social interaction with others. They have not learned to exert themselves in social situations. These situations are unhealthy. But on the other hand, a youth from a home-whether affluent or not-where members are proud of what they are; are humble even in the midst of affluence; respect other peopleôs views and rights, demand their own rights no matter from whom and are not afraid to speak up when the occasion demands, is more likely to interact well in the wider world.

Many youths who leave their homes for the first time may appear to be matured physically but may be emotionally immature Such emotional immaturity derived from poor emotional home climate is often expressed in over-stimulation which leads to responding to situations with irrational fear and other anxieties, both of which affect the status of mental health adversely.

3.6 Scholastic Difficulties

Students are constantly on the move from classrooms, lecture halls, library to dining halls or food canteens. Some live through the hassle quite comfortably, but there are some of these who do not seem to achieve the desired result in spite of all their efforts. Every grade counts towards the class of degree, so some students are constantly on edge. The thought of failing a course is a threat to their peace of mind. The fear of failing a course dangles like an axe over them because it implies

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o offer the course ót the next available
itution.

3.7 Harassment from Teachers

Student harassment in educational institutions in Nigeria never came to the limelight until the issue of sexual harassment in our educational institutions became an issue of public concern within the decade. Student harassment and sexual harassment have always existed in our educational institutions and they have often gone together. Students have been subject of victimization by their teachers for reasons best known to the harasser and often unknown by the harassed. Some students have been excluded from lectures by teachers, deservedly for misdemeanors which needed to be curbed before they spread. However, several instances exist where students have been verbally battered in class or excluded from lectures for no apparent reasons. The number of students who may experience the type of unwanton display of authority by their lecturers may be few, nevertheless the matter of student harassment is real and it is a source of constant worry to those students who see themselves as victims. Student harassment may degenerate into poor making and return of very low scores for harassed studentsô test and examination, or in fact deliberately withholding harassed studentsô scores. This also compounds the studentôs problems which ultimately affects his or her mental health status.

3.8 Poor Sexual Adjustment

Some youths are uneasy in the presence of the opposite sex, with the result that they behave as if they actually hate them. They find it extremely difficult to relate or interact with them in a meaningful way. They probably feel inadequate in a number of ways, including inferiority complex. Some, especially males, speak so much about their escapades with the female sex, but never have the courage to speak or lack a substance of conversation when they meet with the opposite sex. This is generally due to the failure to make necessary adjustments to the female sex in their childhood days. Such youths may probably have no sisters with whom to interact at home. Familiar attitudes towards boy-girl relationships may also implant on the youth a negative attitude towards women. There are other male youths who do not recoil in the presence of the female sex. Rather they would want to treat them as objects rather than persons that should be treated with respect and dignity. This attitude may also have been learned in the home where the father believes in the absolute supremacy of the male sex and the subservience of the female.

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have their own inadequacies. Some may avoid le, because they have been branded evil right from gan to show some interest in the male. These young girls have been brought up to believe that all male advances are geared towards establishing relationships based on purely physical gratifications. Under this type of upbringing the girl grows up, full of distrust and suspicion both of which undermine any meaningful sexual relationship. On the other side of the coin too are categories of adolescents who wear a constant air of superiority and importance that create a barrier between them and any healthy and meaningful boy-girl relationship.

These types of boys and girls described above may appear to be in good mental health but deep down they are actually under some mental stress unknown to them which they unconsciously attempt to cover with some of the several defence mechanisms.

3.9 Search for Future Life Partner

Colleges and universities are settings where the population is largely made up of young men and women. Here youths, particularly women look forward to getting young men with whom they can share their future together. The search for a husband becomes more desperate in the third or final year of study such that it could constitute a serious mental health problem. College and university days are most likely to be the most interesting period of their lives; they are also likely to have the largest number of eligible young men in the same community. Some girls are more subtle in their search while others are more aggressive with such behaviours as showing up at every social gathering such as campus parties, sophisticated dressing, manner of speaking and manner of walking, some girls even give the impression of being reserved, with the hope to be noticed by a serious-minded male student who is also searching for a future partner. If an impression that worrying about marriage is only found on the doorsteps of female students had been created, it is because female students are more mentally affected. There are reports of incidents of near suicides and actual suicides on account of alleged jilting.

3.10 Problems of Drug Abuse

Drug abuse and misuse are both mental health problems which are common in Nigeria, particularly among the youths in our tertiary institutions. A normal person would neither misuse nor abuse drugs on a regular basis. However, there are some legitimate reasons and cases why one may need to use drugs. Under certain situations the use of drugs becomes legitimate especially when used under medical instructions.

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...that misuse and abuse of drugs have ... as well as the socio-psychological ... drugs to solve their problems. Such socio-psychological problems include search for identity which is a common reason given among youths; the desire to reduce tension and anxiety or to remove fatigue and boredom. Other reasons given include the desire to change oneôs mood, activity level, or to improve social interactions and relationships; the desire for group conformity as well as the desire to ójust feel goodô. The fact of the matter is that there are several other positive actions or behaviour that can produce a more positive and healthy result.

3.11 Inadequacy of Basic Services and Facilities

Nigerian youths in colleges and universities, like the other persons in the large community encounter problems emanating from lack of essential services and facilities. For instance, inconsistency in water supply and electricity, lack of adequate library space, poor environmental sanitation in halls of residence and classrooms, overcrowding in lecture halls of residence and classrooms which over-stretch the meager facilities ï all affect the productivity and effectiveness of the students. Since most students want to do well in their studies, any situation as those mentioned above will undermine their mental health.

4.0 CONCLUSION

There are some mental health problems which affect youths in our society and some of these youths attempt to solve these problems psychologically through habits which further land them into more serious psychological and physical problems. There are those that turn to drugs and some other solutions that seem fit for their problems.

5.0 SUMMARY

We have examined some of the mental health problems which impinge on the youths. A considerable number of the problems emanate from inability of youths to handle satisfactorily socio-psychological problems such as those related to boy-girl relationships, peer group relationships.

6.0 TUTOR-MARKED ASSIGNMENT

1. What is loneliness? How can it affect mental health?
2. Explain how the social and emotional adjustment at home can influence the mental health development of the youth.

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EGIES AND DEFENCE

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1.0 INTRODUCTION

This unit examines the ways individuals reacts to stressful situations and how best to minimize its impact on our mental health.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- distinguish between coping strategies and defence mechanisms
- identify the major types of coping strategies and describe how each operates
- list the different types of defence mechanisms.

3.0 MAIN CONTENT

3.1 Coping Devices and Defence Mechanism

You will recall that we are constantly being affected by situations in our everyday life which generate various degrees of stress; some are minor and others are very serious and we react to these either consciously or unconsciously; with or without the full knowledge of what we are doing. When we react in a conscious way to a stressful situation, we are said to be coping. In other words, we are applying a coping strategy. On the other hand when we react to a stressful situation unconsciously, we are said to be employing defence mechanism. In other words, defence mechanisms are activities or reactions, patterns, usually unconscious that protects a person from anxiety, guilt, unacceptable impulses and internal conflict.

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ategies

r types of coping strategies:

1. Less desirable coping activities.

2. Aimless and unproductive coping activities.

3. Desirable and helpful coping activities.

Less desirable coping activities

These are activities which are very harmful both physiologically and psychologically. The activities include over-eating, alcohol consumption, smoking and indulging in drug abuse:

1. Over-eating

Too much eating is generally accomplished with inactivity. The over-eating may then lead to hypertension, obesity, unattractiveness and a host of other psycho-physiological problems.

2. Alcohol consumption

Alcohol is classified as a systemic drug which is conveyed directly to the bloodstream and acts on the central nervous system, with both psychological and physiological consequences, such as cirrhosis of the liver, reduced appetite, malnutrition and impaired normal mental activities. People consume alcohol to run away from their problems but the problems remain after the effect of alcohol is gone.

3. Use of tobacco products

Some individuals when understress resort to smoking, which they claim calms their nerves or stimulates their ability to think. This is a conscious action which does not help the person in any way whatsoever. No matter how much tobacco products one uses and in whatever form it is used, tobacco remains detrimental to human health because of the harmful effects of the chemicals ï nicotine, tar and carbon monoxide on the body systems. Some of the consequences include cancer (of the lung, oesophagus, bladder, kidney, larynx and oral cancer), bronchitis, emphysema, stroke, heart attack, cirrhosis of the liver, stomach and duodenal ulcers and other circulatory and heart diseases.

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...r psychoactive substances when they want to think, sleep, attend functions, be alert, keep awake and to be able to function effectively in a variety of situations. All drugs alter the chemical composition of the body as well as affect in various degrees the central nervous system. So even the prescription drugs taken without medical advice can be dangerous to health. Drugs taken out of frustration and purposes other than prescribed medication include depressants, stimulants, tranquilisers, opiates and narcotics. Some of the known hazards of indiscriminate ingestion of these drugs include drug dependency, addiction and tolerance, mental disorders, crime, impaired functioning of the organs physiological problems and even death.

Aimless and unproductive coping activities

These are activities which are harmless and which may appear to reduce tension emanating from stress. They are however found to be unproductive. They include such pointless activities as:

1. Floor-pacing, hand-wringing, nail-biting, teeth-grinding, finger-tapping on an object, scratching the body and other aimless activities. These are called impulsive behaviour

2. Day dreaming which is a retreat from reality to fantasy in which a personôs problems do not appear to exist or appear to have been solved. Occasional day dreaming of short duration is harmless, but it becomes dangerous when the habit is for long duration or becomes chronic, thus hampering the opportunity to face the reality of the situation.

Desirable and helpful activities

Some coping activities are helpful and therefore desirable in the reduction of tension generated by stress:

1. Laughing, crying and swearing

These are natural activities of everyday life. One cries under stress which may be positively or negatively induced. Both negatively and positively induced stress often generate emotion which is expressed by the shedding of tears. Thus one cries when there is a loss of a significant person such as a parent, sibling or a close friend. Generally, the death of a person whether well-known or mere acquaintance, may also elicit tears of sympathy. Also, a happy occasion such as seeing a relation one has not seen for years or achieving an unanticipated success after a long

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ay elicit a cry of joy. In other words, both sad and uld create such tension that they are expressed in bly lets out the tension.

In view of the value of crying, people should not be unduly restrained from crying when an immediate solution calls for it, especially under the circumstances described above. It is better to cry it out when one is in distress such as when one is grieving for the loss of a significant person, rather than bottle the emotion up.

Swearing helps to relieve tension, whether or not the object, is aware of the swearing or not. Swearing here does not imply the use of the name of God or whatever the swearer believes in. It means expressing oneôs displeasure with the visible cause of stress or tension. Such an action generates some stress on the patient law-abiding driver who may then expresses his displeasure by saying ñLook at that foolish man!ò or ñLook at that mad man!ò or ñLook at that selfish man who thinks I have no need to hurry!ò and so on.

Laughing also helps in the reduction of stress and it could be used for both joyous and sad occasions. More importantly when you learn to laugh at yourself and at your actions in an attempt to solve your problems, rather than brooding over them, you are exhibiting signs of good mental health.

2. Talking out a problem

Talking out your problem with a close person such as your spouse, close friend, classmate, the teacher you can trust or even your religious leader or an elderly person in your family can make a lot of difference in the reduction of a problematic tension. Your listener may not have a ready solution to your problem, but you would have reduced your burden because someone now shares some of it. From talking out your problem, you may start having an insight to its solution.

Talking out a problem also includes seeking professional assistance such as a psychologist or a psychiatrist. A problem which bothers your mind is like a disease which affects your body. There should be no shame in seeking for help when you believe you have a tension which appears to linger on, and with no apparent solution.

3. Thinking through a situation

When you have been through an unpleasant experience or have been badly hurt emotionally, it is always good to give yourself a few moments of unemotional thinking to help you put things in better

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...situation. The few moments here may ... You are then in a better position after ...ide on an appropriate action. Rash decisions may satisfy the spur of the moment, which may in the final analysis further complicate your problem rather than solving it. For good mental health, you must cultivate the habit of thinking over a situation thoroughly before acting. It is better not to act on the spur of the moment than to regret later.

La Placeôs (1987) adaptation of Louis E. Kopolowôs *"Plain Talk about Handling Stress"* into his *"Twelve Tips on how to cope with Stress"* summarises the coping modalities for stress.

1. Try physical activity

Vigorous exercise of any kind relieves uptight feelings and ushers in relaxation.

2. Talk out your worries

Donôt hide your worries. Ask for help when you need. For really serious problems seek professional help.

3. Know your limits

Learn to accept what you cannot change. Donôt fight a situation, if it is beyond you.

4. Don't mask your problems with hard drugs and alcohol

Although drugs and alcohol relieve stress temporarily, they do nothing to alleviate stress conditions that caused the stress in the first place.

5. Take care of your health

Eat well and get enough rest every day. You will be less able to deal with stressful situations if you neglect your diet and loose sleep.

6. Make time for fun

Play is just as important to your well-being as work. It is essential to allow time for amusement and recreation.

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with others

When you are bored, sad and lonely, get out and go where itôs all happening. Offer service to neighbourhood and volunteer organizations. Help yourself by helping others.

8. Organise your time

Donôt try to do everything at once. Rank your tasks in order of importance and concentrate on the essential ones first.

9. Give in once in a while

You donôt always have to be right. Donôt let other people upset you because they do not do things your way.

10. Realise that it is all right to cry

Relieve your anxiety with a good cry. It may prevent headache and other physical symptoms.

11. Create your own peace and quiet

You cannot get away from your problems; try imagining a quiet country scene or a deserted beach. Escape into the pages of a good book or play some music you enjoy. Any one of these activities can induce a sense of peace and tranquility.

12. Learn how to relax

The next time you feel tight and tense, take deep breaths. It works wonders in reducing tension. The relaxation technique titled *The Relaxation Response* developed Benson, (1975), can relieve most symptoms of stress and can be used anywhere anytime.

The Relaxation Response Developed by Herbert Benson, M. D. and Miriam Z. Khpper

1. Sit quietly in a comfortable position.

2. Close your eyes.

3. Deeply relax your muscles, beginning at your feet and progressing up to your face. Keep them relaxed.

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Become aware of your breathing. As ...word ñONEò silently to yourself. For ...UT, ñONEò, etc. Breathe easily and naturally.

5. Continue for 10 to 20 minutes. You may open your eyes to check the time, but do not use an alarm.
   When you finish, sit quietly for several minutes, at first with your eyes closed and later with your eyes opened. Do not stand up for a few minutes.

6. Do not worry whether you are successful in achieving a deep level of relaxation. Maintain a passive attitude and permit relaxation to occur at its own pace. When distracting thoughts occur, try to ignore them by not dwelling upon them and return to repeating on ñONEò. Practice the technique once or twice daily, but not within two hours after any meal since the digestive processes seem to interfere with elicitation of the Relaxation Response.

3.2 Defence Mechanism

Defence mechanisms are sometimes referred to as defence-oriented reaction. Stressful situations are part of everyday life and everyone develops methods of handling them. The less stressful situations are handled consciously as already discussed under coping strategies. But the use of ego-mechanisms helps an individual to avoid a conscious feeling of the presence of stress.

There are no disagreements that defence mechanisms do exist, but there appear to be disagreement on how many of these there are and to which mechanisms a particular pattern of behaviour should be attributed. It is generally known that defence mechanisms are called into play whenever a situation or impulse or feeling comes up which is in conflict with a personôs self-concept. These defence mechanisms should not be regarded as abnormal, for we all make use of them and we all cannot be said to be abnormal.

Defence mechanisms are necessary and valuable in dealing with the stressful situations we all face through life. It is most doubtful that anyone can successfully go through life without making use of some of them at one time or the other. However, reliance on them or inability to acknowledge or accept them can be a sign of low ego strength. This becomes even more difficult when we realize that most defence mechanisms are unconsciously motivated; that is, we do not know why we do them and when we do them. It requires an intelligent outsider to

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happening. In examining a few of the widely echanisms, no attempt is made to classify them as t cases, the value of a particular device depends on the extent to which it is used. A defence mechanism might be of great value if used in moderation and in proper situations. Yet, the same mechanism used in excess or in inappropriate situations may be very harmful. By and large, defence mechanisms are automatic responses that help one to alleviate or avoid stress rather than solving the problem which has generated it. The following are some of the more commonly used defence mechanisms found in the literature:

1. Avoidance

This is the simplest and most common method of defence against anxiety. It operates by avoiding situations that produce anxiety. Every one of us uses this defence to some extent. If you are afraid to speed, you will always prefer to travel with a slow vehicle. In the same way, if you feel very uncomfortable speaking in the public or in front of groups, you will try to avoid situations in which you will be required to make public speeches. A young man who feels uneasy in a personal relationship with girls will avoid this anxiety by not asking them for dates. But this may not debar him from speaking of his exploits with them. In the normal run of things the above examples of avoidance could neither be considered abnormal nor unusual. However avoidance according to Jones, Shainberg and Byer (1974) could become so intense if a person becomes so fearful that he refuses to venture out of his house for any reason. Thus, it can be that the same defence mechanism can be normal and harmless or seriously disabling depending on the degree to which it is utilized.

2. Compensation

The defence mechanism by which a person counter-balances failure in one area by excelling in another. This mechanism is in constant use and even more so by the disabled person. For instance, the visually impaired often develop a high sense of hearing and remembering voices.

3. Denial of reality

This is a defence reaction in which a person protects his ego from a stressful situation by refusing to perceive it or withdrawing from it. An example is a situation in which a motorcyclist disregards safety rules by riding without a crash helmet or a child ignores the motherôs call to come home simply because he wants to play in the friendôs house. Another variation is the denial of the inward feelings as in the case of a youth who might deny his feelings or desire for a girl if he knows he has

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...verbial ñthe grapes are sourò is a good ...me defence mechanism against objects ...ve is out of our reach. We generally avoid anxiety by restricting our most cherished desire to that which is attainable or nearly so (Jones, Shainberg and Byer, 1974).

4. Displacement

This is transference of an emotion from the situation that caused it to a less stressful or threatening situation.

5. Dissociation

This defence mechanism involves divorcing ideas from the feelings that would naturally be associated with them by satisfying contradictory motives. For instance, the person who leads a normal life in the midst of chaotic world conditions.

6. Fantasy

This is an escape into a dream world to avoid reality. In fantasy, a person imagines he is someone else he is obviously not, such as a movie star, an intellectual giant or a successful business executive.

7. Fixation

In a fixation, a person remains emotionally immature either in all phases of his personality or in only certain aspects of it. This type of person may never gain emotional maturity or he may gain it at a later than average age. It is closely related to regression except that a person may never have advanced beyond the childish age.

8. Projection

This is a defence mechanism in which a person attributes his own motives to others or blames someone else for his own problems. For instance, a person tells lies and cheats because he believes that everyone does the same, or a person accuses others of doing what he does or would like to do.

9. Rationalisation

This is a behaviour in which a person convinces himself that his reasons for doing something are different from what they really are; an individual explains his behaviour in such a way as to assign a socially acceptable motive to it and disguise the unacceptable motive his

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ortrays. Rationalization is a commonly used defence example is a student who fails a quiz but blames the is inadequate efforts or preparation for the quiz.

10. Regression

A return to a former somewhat primitive and rather childish type of reaction. An example is an undergraduate who leaves the university and returns home because life is tough in the former and easier in the latter. Regression is closely related to fixation in terms of childish type of reaction except that a person who exhibits fixated reactions has never grown beyond his immature stage of development.

11. Repression

This is the unconscious forgetfulness of aspects of past events that may cause pain or discomfort. Example is the case of a soldier who has seen many horrible sights of deaths on the battlefield and refuses to let the events pass through his thoughts. While repression has its positive aspects, it is damaging when it protects a person from problems he should face realistically.

12. Sympathism

Avoidance of a problem by seeking attention and expression of concern over difficulties. Example is the case of a student who fails a course and then seeks sympathy of others; explaining the failure as not his fault, but the lecturerôs for setting difficult questions. This mechanism is closely related to rationalization.

13. Transference

This can be either a positive or negative shifting of feelings from one person to another because one identifies with the two. Example is the case of a person to whom another is introduced to resembling a friend. The person tends to be attracted immediately to the new person.

14. Sublimation

Sublimation which was originally used to indicate the process of satisfying frustrated sexual desires in no-sexual substitute activities is now used more commonly to include any substitution, actions and thoughts which are considered undesirable or unacceptable. For example, expression of aggressive impulses towards others in the form of destructive behaviours or acts that are not socially acceptable can be

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orms of competition such as in sports,

Defence mechanisms/reactions used infrequently are not altogether harmful to the individualôs personality. Whether they help in coping or lead to maladjustment behaviour depends upon the specific type of mechanism and its effect on you or others and upon the extent to which you and others learn to depend on one or more of them. Therefore, defence mechanisms leads to maladjustment when they interfere with objective self-analysis and when they prevent a direct attack on a problem by concealing its true nature.

SELF ASSESSMENT EXERCISE 2

What is the major difference between Sympathism and Sublimation?

4.0 CONCLUSION

As we have seen in this unit, coping devices are methods of making necessary adaptation to stress experienced in our environment. Coping is generally a conscious reaction to stress. The coping strategies help to reduce stress by achieving an indirect satisfaction of a need. Defence mechanisms are also a kind of adaptation or coping. They are also learned behaviour but often used unconsciously, they are common practice in everyday life.

5.0 SUMMARY

You have gone through coping strategies and defence mechanism in this unit. There are many defence oriented actions employed by us and some of these include avoidance, compensation, denial of reality, displacement, dissociation, fantasy, fixation etc.

6.0 TUTOR-MARKED ASSIGNMENT

1. Defence mechanisms and coping strategies are closely related. In what ways are they similar and dissimilar?
2. List 10 types of defence mechanisms and briefly describe five of them.

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SES OF MENTAL ILLNESS

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1.0 Introduction
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1.0 INTRODUCTION

This unit will expose the learner to various causes of mental illness.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- identify the causes of mental illness
- discuss the identified causes.

3.0 MAIN CONTENT

3.1 Causes of Psychiatric Disorders

No single set of facts can be considered separately when seeking the causes of mental illness. In most cases, it is impossible to ascribe a mental illness to one particular cause and for the most part a possible aetiology must be recognized.

Causes of psychiatric illness come either: (1) The predisposing causes, or (2) The Exciting (or Precipitating) causes. The Predisposing causes are conditions which exist in the individual and render him liable to a mental breakdown. The exciting causes are those conditions which give rise to the actual breakdown. The exciting cause is, as it were the match which sets fire to the trail of gunpowder which represents the predisposing cause.

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Heredity

It has been shown by the study of twins that heredity plays an important part in certain mental illnesses. Monozygotic twins (identical) are born with the same genetic makeup whereas dizygotic twins are no more closely related genetically than other brothers and sisters.

In Schizophrenia 65% of the Uniovular twins showed similar features mentally. For instance, both were completely normal or both had Schizophrenia or both showed mild abnormalities. This only occurs in 15% of binovular twins. In manic depressive illness the figures for Uniovular twins was 70% and for binovular twins 15%. This emphasizes the importance of heredity at any rate in the forms of mental illness.

Another method by which the degree of heredity plays a part can be estimated by comparing the frequency of a particular form of mental illness in the relatives of the patient suffering from it with the frequency of its occurrence in the general population. Obviously the higher the incidence among the patientôs relatives the greater is the hereditary factor.

Faulty upbringing

The over-anxious, fussy parent may cause a child to be anxious and lacking in confidence while permissive may lead to an undisciplined child who may show tantrums, jealousy.

3.3 General Causes

Age

In old age there is a decline in both the mental and physical spheres as a result of natural wear and tear. Also women during the child bearing period of their lives have to face the added stresses of pregnancy and puerperium. Thus, as a result of child birth, few women suffer from Puerperal Psychosis; and at old age, they suffer from Senile Psychosis, Senile Dementia.

Sex

Males do suffer from certain psychiatric problems more than the females. For example, males get more indulged in Indian hemp smoking than the females. Whereas females get more worried, they react badly to

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develop mental illness. Paranoid states are common
en.

3.4 Exciting (or Precipitating) Causes

Physical factors

These include infections, intoxications, endocrine, circulatory, nutritional disturbances and trauma.

Infections and toxins

Any generalised infection may produce a mental illness usually of the confusional or delirious type. The level of the temperature does not seem to be any criterion as to when mental symptoms will occur, but probably these depend more on the predisposition of the patient. (For example patients with hyperpyrexia do talk irrationally if the temperature is not controlled on time).

Such mental illnesses may be found with pneumonia, typhoid, scarlet fever, influenza, septicaemia and syphilis.

Trauma

Trauma is a major cause of psychiatric illnesses. This could be as a result of a fall from a height, forceps delivery or road traffic accident in which results in direct damage to the brain thus impairing the normal function of the brain or as a result of rape, natural disaster or loses.

3.5 Mental (or Psychological) Causes

Some social factors are of great importance and may lead to mental breakdown. Unemployment leads to reduction in income which may cause malnutrition through lack of food. A predisposed individual develops mental illness, whereas in the individual who shows no predisposition, apart from a natural depression and anxiety regarding his family, no symptoms may occur. Environmental stresses resulting from industrialization, mechanization, increased competition for jobs contribute to the incidence of mental illness. Sudden stress e.g. grief of dead person, business worry etc. could be a contributing factor.

3.6 Prevention of Mental Illness

Until there is a clear definition of mental illness, it will be difficult to know exactly what preventive measures are required. However, there are some clues that suggest that a child needs to be provided with emotional

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provide for the emotional and social

One approach to preventing mental illness in individuals living in a community is to improve the environmental and social conditions existing in the community. A stable, secure, loving family life assists individuals to develop attitudes about self and others that make it possible to adjust to the pressures of adulthood and to live a satisfying and productive life.

Many authorities believe that prevention of mental illness will not be achieved on a widespread scale until efforts are directed at improving the quality of life for all persons in our society. These authorities conclude that many of our social problems such as poor housing, racial, religious and sexual discrimination and unavailability of quality healthcare to all are major elements in the cause of mental illness. Therefore, these persons support broad social reform programs designed to alter the basis of these social ills.

3.7 Prevention of Mental Illness

Prevention of mental illness has been an important goal of epidemiologists in public health. Preventive psychiatry is characterized by 3 types of prevention (Caplan, 1964). *Primary Prevention* reduces or eliminates the incidence of symptoms and signs of mental disorders; it stops illness (morbidity) and perhaps mortality before it occurs. *Secondary prevention* reduces the prevalence of mental illness without directly altering its incidence by early treatment of acute cases, reducing the duration of illness and its associated morbidity and mortality. *Tertiary prevention* reduces the morbidity and mortality rates associated with mental disorders by rehabilitation, the incidence and prevalence of the disorders are not affected, although pain and suffering may be relieved.

Effective prevention requires specifying the disorder or problem to be prevented, demonstrating risk factors and identifying and evaluating proposed interventions. Psychiatric epidemiology provides the specific basis of preventive psychiatry.

Primary prevention of organic mental disorders and mental retardation has benefited from epidemiological data. Some investigators have expanded the concept of primary prevention to include *Health Prevention* through activities that improve the quality of life and prepare individuals in a general way for adapting to life stresses.

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ION

The various causes of psychiatric disorders are interrelated, so no single cause can be considered as an entity when seeking the cause of mental disorder. Thus, the learner must explore all the causes and proper understanding of these causes will assist in no small measure in the prevention of mental illness in our society.

5.0 SUMMARY

In this unit, we looked at causes of mental illness such as predisposing and exciting causes with the preventive measures. It is hoped that you have increased your knowledge by going through this unit.

6.0 TUTOR-MARKED ASSIGNMENT

Differentiate between predisposing and exciting causes of mental illness.

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GNS AND SYMPTOMS OF RDERS

CONTENTS

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1.0 INTRODUCTION

The previous unit examined the causes of mental disorders. The predisposing and precipitating factors as well as the preventive measure were considered. Here, the general signs and symptoms of mental illness shall be looked at.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- list the general signs and symptoms of mental illness
- explain at least four general signs and symptoms of mental illness identified above
- list the various examinations that can be made on a mentally ill patient.

3.0 MAIN CONTENT

3.1 General Signs and Symptoms of Mental Illness

In different forms of mental disease, the symptoms explained below are various manifestations, namely:

(i) Disturbances of behaviour: motor behaviour (comprises bodily movement and stream of talk).

(ii) Emotional Reaction

(iii) Delusions

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(vi) Disturbance of memory

(vii) Disorders of intelligence.

(i) Disturbances of Behaviour

Very common with many psychiatric illnesses a change in behaviour or conduct is one of the earliest symptoms.

Motor behaviour comprises of bodily movement and stream of talk.

(a) Bodily movement

This may increase as in case of mania or catatonic excitement and may consist of rapidly succeeding purposeful acts. Manifestations involving bodily movement include:

Stereotype of movement

Overactivity characteristic in the same type of movement being monotonously repeated for hours at a time.

Verbigeration

Monotonous repetition of phrases

Negativism

Consists in the patient doing the exact opposite of what is asked of him e.g. shutting the eyes when told to open them etc.

Restiveness

The patient actively opposes or resists anything he is asked to do or is being done for him, e.g. in schizophrenic patients.

Impulsiveness

A sudden outburst of activity (at times due to hallucination) e.g. in manic or schizophrenic patient.

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This is slowing down of bodily movement, combined with slowing of thought.

Stupor

Means complete suppression of speech, thought and action. It is more common in schizophrenic states than in depressive ones.

Flexibilitas cerea

A curious ñwax-likeò rigidity of the muscles.

Catalepsy

Maintenance of uncomfortable postures for long periods.

Automatic obedience

Common with schizophrenic patients. This includes automatic repetition of action (echopraxia) or repetition of phrases or words heard (echolalia).

(b) Stream talk

Mustism

Unwillingness to talk as seen in catatonic schizophrenia.

Flight of ideas

Patients think fast, their associations are superficial and are often guided by rhymes and distracted by change objects in the environment (distractibility). These disturbances of thoughts and stream of talk constitute flight of ideas.

Incoherence

The sequence of the talk or speech is broken into fragments.

Blocking (or sudden stoppage)

Occurs in schizophrenia.

Patient breaks or stops discussion or speech.

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action

affects are both used to denote emotional reaction.

Elation

Excessive joy which is not in keeping with the patientôs actual circumstances; example is seen in manic patient.

Euphoria

This is generalized feeling of well-being, seen in manic and some alcoholic patients.

Incongruity of affect

Patient refers to most horrible experiences in a jocular manner, e.g. patient laughs when told that a close relation is dead. Patient with schizophrenia is a good example.

Flattening of affect

Patient manifests little emotional reaction to either joyful or sorrowful stimuli i.e. patient feels indifferent to situation. This is manifested by Schizophrenic patient.

(iii) Delusions

Delusions are false beliefs which are not true to fact, cannot be corrected by an appeal to reason or logic and are not in keeping with the individualôs environment and education.

Types of Delusions

(a) Delusions related to depressive illnesses:

1. **Self-reproach:** It occurs as a result of incomplete repression and results in feelings of guilt being left behind. Patient often state heôs unfit to live, to receive food, to mix with his fellow men etc.

2. **Hypochondriacal:** Patient is convinced that there is something wrong with his body in the absence of a physical disease. Patient may complain he has cancer, heôs unable to swallow, his bowels donôt open, he has tumor etc. This is manifested with involutional depression.

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...es he has no money; despite the fact ...onaire before illness.

4. **Nihilistic:** Patient says that there is no world, he does not exist, and that his body is dead, etc. This type of delusion is present in patient with involutional type of depression.

Ideas of unreality

Related to nihilistic delusions but the patient recognizes his abnormality. Patient feels as if everything has changed and that things look different and unreal.

Depersonalization

Patient complains that he is a different person; and he cannot feel any emotion.

(b) Delusion of grandeur (or Grandoise delusion)

The patient states he has untold wealth influence, or power or being an outstanding, famous or notorious person, or historic or religious figure. It occurs most commonly in mania; also in states of excitement and general paralysis.

(c) Paranoid delusions (i.e. Delusion of persecution) in schizophrenia (Paranoid schizophrenia)

Ideas of persecution of being followed, watched, slandered, having oneôs mind controlled or influenced, of being harmed physically, or plots against oneôs life. Patient may state that the food is poisoned. Delusions of persecution often arise as a result of hallucinations.

Ideas of reference

Consist in the patient thinking that something in his surrounding is intended to have a meaning for him when no such meaning is intended e.g. a cough in the patientôs vicinity is an insult, or an article in a newspaper refers to him. Ideas of reference are based on some external circumstance and are more open to reason than delusions. Patients with paranoid schizophrenia manifest this symptom.

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Patient feels he is influenced by an outside agency or force e.g. that heôs influenced by wireless or his thoughts are read and controlled by some supernatural power - common with schizophrenic patient.

(iv) Hallucinations

Hallucinations may be described as false sensory perceptions without an external stimulus e.g. patient may claim to see an animal when no animal is present suffering from visual hallucination.

Types of Hallucination

Auditory hallucination

This affects the organ of hearing (ear). It consists of voices talking to the patient. Often they call the patient unpleasant names; he hears shots being fired at him. At times some of the patientôs impulsive behaviour is due to auditory hallucinations. Schizophrenic patient and patients in toxic confusional states manifest auditory hallucination.

Visual hallucination

It affects the eye. Patient sees imaginary images. He claims to be seeing human beings or animals here none is present. It is common in toxic confusional state and schizophrenia.

Hallucinations of smell and taste

They are often associated; the patient stating his room has an unpleasant odour and his food has a peculiar taste. Such hallucinations often act as a basis for persecutory delusions, viz; that his food is being tampered with.

Hallucinations of touch (Tactile)

Take the form of insects crawling under the skin or of being touched and blown upon.

Illusions

Illusions are real perceptions falsified and depend on misinterpretation of external stimuli. A person who mistakes the rustle of leaves for someone talking is the subject of an auditory illusion.

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where the patient mistakes the pattern

(v) Orientation

Orientation is oneôs appreciation of time, space and personal relations at the present moment.

In confusional and delirious states, the patientôs appreciation of time, space and personal relations may be wholly or partially disturbed. In the former case, disorientation is said to be complete, while in the latter it is said to be partial.

Where complete disorientation is present, the patient cannot correctly state who he is, where he is and has no idea of time or place. He is then said to be disorientated for time and place.

3.2 Observation and Examination of Psychiatric Patients

Psychiatric nurses deals with patients presenting with various forms of mental illness. However, what they all have in common are disturbances affecting their behaviour, emotions, thinking and perception. Perhaps most important of all is the recognition that psychiatric illness occurs when these disturbances affect the individualsôgeneral functioning.

The following are examined to recognize psychiatric illness in any patient. These are the patientôs:

(1) Behaviour and Appearance

(2) Mood or Affect

(3) Perception

(4) Thought content

(5) Intelligence level

(6) Memory

(7) Concentration

(8) Orientation ï in space, time and person and by discerning abnormalities make a clinical diagnosis.

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ining a psychiatric patient therefore, the students nber:

(a) To listen carefully.

(b) To record conscientiously.

(c) To avoid interpreting and speculating about what he supposes the patient means.

(d) To get a history from as many informants as possible.

(e) Only to use words that he understands.

i. Behaviour and Appearance

Appearance

Much may be observed from the patientôs physical appearance: his dress, state of body hygiene and grooming. Are they appropriate to his position? The banker who comes from his office unshaven and dirty and who does not seem to recognize the inappropriateness of his appearance must be evaluated differently from the construction worker with similar appearance.

Observe facial expressions, body and limb movements and mannerisms - and note particularly how they change with the topic of conversation. Staring into space or through the examiner/observer as if preoccupied, with sudden head or body movements, may be the first hint of hallucinations.

Strange postures, stereotyped movements such as grimacing tics, apparently spontaneous emotional outbursts, rigidity of expression and physical withdrawal should be noted.

Behaviour

Observe the general manner in which the patient approaches and reacts to the interview or discussion. Is he cooperative, frank, open, fearful, hostile, reticent? Does his general attitude change during interview?

ii. Mood or affect

The level of and changes in feeling is a sensitive index of emotional illness. These are many possible moods: depression, elation, euphoria,

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..., panic, hostility, calm, happiness, ... these.

Bizarrely inappropriate moods may be observed in some patients suffering from schizophrenia, depressed patients may show a mood appropriate in direction but excessive in degree. Patients with organic brain damage may show wide fluctuations in mood in response to seemingly trivial stimulus ï so called ñmood liabilityò.

iii. Perception

Perception is the process of becoming aware of something through one of the senses, i.e seeing, hearing, smelling, tasting or touching.

The nurse should note if there are faulty perceptions, specify nature of perception.

iv. Thought content

In observing and recording abnormalities of thought, it is necessary to distinguish between what is directly presented and what is inferred, nothing in the latter the basis for the inference. Delusions or hallucinations should be considered.

While thought content abnormalities may be bizarre and obvious, they may also be quite subtle and not readily revealed by the patient, particularly if he has encountered a hostile or incredulous response upon previous attempts to say what is in his mind. The patientôs general attitude and behaviour may offer clues.

A patient who speaks as if in reply to a voice may be asked, ñCould you tell me what the voice just said to you?ò i.e. a deliberately leading question should be asked, rather than, ñAre you hearing voices?ò which often prompts a false negative reply.

v. Intelligence level

Tests of general information should be geared to the patientôs experience, interest and level of education.

A gross measure of the patientôs intelligence can be derived from his account of his history, general knowledge and reasoning powers.

Tests of a general information should be geared to the patientôs experience, interest and level of education. As with memory tests, the examiner/observer ought to develop standard questions, e.g. ñCan you name the President?ò Who was the President before him? What is the capital of Nigeria? etc.

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Assess the memory of the patient ï especially when responding to questions or narrating a story. Any amnesia? ï anterograde and retrograde amnesia; paramnesia or hyperamnesia.

vii. Concentration

Making change mentally and serially (subtracting 7 from 100 for the simpler 4 from 25) are useful tests of concentration but the observer must make certain that inability to do mental arithmetic is not the cause of failure or slowness. Telling the months of the year or the days of the week in reverse order are better tests of concentration for poorly educated patients.

viii. Orientation

Three areas of orientation are classically tested ï person, time and place. The sense of personal identity is usually the last to be lost in organic brain damage, but its loss is the presenting complaint in hysterical amnesia.

ix. Insight

While insight alone cannot be used to assess the patientôs full appreciation of acceptance of his mental state, it helps to measure or assess ï to some extent the chronicity of the illness. Not every psychiatric patient can be said to have insight and not all donôt, it is however a method of observing and judging patientôs mental state.

Specific Observation of Psychiatric Patients on Hospital Admission

While on admission, psychiatric patients need some specific observations which contribute/hasten the recovery. Type of patient/nature of illness, time/shift, type of medical/nursing care being given to patient, specific or special care ï like opening of charts, e.g. sleep chart, suicidal caution (chart), must be noted.

The very restless/disturbed patients should be duly observed and preferably kept within nurses vicinity to prevent them from absconding from the hospital or wandering away.

Patients with tendency to commit suicide should not be allowed to stay alone especially in the toilet or bathroom. Observe bedside for dangerous instruments or drugs that might be kept by patient.

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ecially in the night should be observed on of hallucination, delusion or other radio, television, presence of light (electricity) not put off or unwarranted anxiety could disturb patients sleep. Encouraging patients to read newspapers, group or individual psychotherapy, occupational and recreational therapies afford nurses to observe patients without allowing the patient the knowledge of method. Adequate observation contributes to the management of patients as many complaints/manifestations not given by patient or his relations can be detected by the nurses who stay with the client much more than other members of the psychiatric team.

4.0 CONCLUSION

This unit looked into the general signs and symptoms of mental illness such as disturbances of behaviour, emotional reaction, delusions, hallucinations, orientation, disturbance of memory and disorders of intelligence.

5.0 SUMMARY

No doubt the unit is very exciting as we have gone through several manifestations of mental illness which must have increased your knowledge as a learner.

6.0 TUTOR-MARKED ASSIGNMENT

1. List the seven general signs and symptoms discussed in this unit.
2. Explain **any three** of the general signs and symptoms.

7.0 REFERENCES/FURTHER READING

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Unit 1 Classification of Mental Disorders
Unit 2 Stress and Mental Health
Unit 3 Personality Disorders
Unit 4 Psychiatric Emergencies
Unit 5 Disorders of Childhood Psychiatry I
Unit 6 Disorders of Childhood Psychiatry II

UNIT 1 CLASSIFICATION OF MENTAL DISORDERS

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Contents
  3.1 Modern Classification of Mental Disorders
  3.2 Group II Classification
4.0 Conclusion
5.0 Summary
6.0 Tutor-Marked Assignment
7.0 References/Further Reading

1.0 INTRODUCTION

Classification is a process by which complex phenomena are organized into categories, classes or ranks, so as to bring together those things that must resemble each other and to separate those that differ. There are two categories of classification that will be presented to learners i.e. modern and old ways of classification of mental disorders. We do hope the learners will be able to differentiate between these two categories.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- differentiate between the concept of normal and abnormal behaviours
- classify mental disorders by modern method.

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3.1 Modern Classification of Mental Disorders

Classification is a process by which complex phenomena are organized into categories. Like any growing branch of medicine, psychiatry has been rapidly changing in classification to keep with a conglomeration of growing research data dealing with epidemiology, symptomatology, prognostic factors, treatment methods and new theories for causation of psychiatric disorders. At present, there are two major classifications in psychiatry, namely, ICD10 (1992) and DSMIV (1994).

I. ICD10 (International Statistical Classification of Disease and Related Health Problems) - 1992

This is WHOôs classification for all diseases and related problems. The chapter ôFô classifies psychiatric disorders as mental and behavioural disorders and codes them on an alphanumeric system from F00 to F99.
The main categories in ICD10 are as follows (taken from Dr Ahujaôs STB psychiatry):

F00-F09 Organic, Including Symptomatic Mental Disorders

F00 Dementia in Alzhiemerôs disease

F01 Vascular dementia

F04 Organic amnestic syndrome

F05 Delirium

F06 Other mental disorders due to brain damage and dysfunction and to physical disease

F07 Personality and behavioural disorders due to brain disease, damage and dysfunction

F10-F19 Mental and Behavioural Disorders Due to Psychoactive Substance Use

F10 Mental and behavioural disorders due to use of alcohol

F11 Mental and behavioural disorders due to use of opioids

F12 Mental and behavioural disorders due to use of cannabinoids

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behavioural disorders due to use of sedatives or hypnotics

F14 Mental and behavioural disorders due to use of cocaine

F16 Mental and behavioural disorders due to use of hallucinoges

F20-F29 Schizophrenia, Schizotypal and Delusional Disorders

F20 Schizophrenia

F20.0 paranoid schizophrenia

F20.1 hebephrenic schizophrenia

F20.1 catatonic schizophrenia

F20.3 undifferentiated schizophrenia

F20.4 post- schizophrenic depression

F20.5 residual schizophrenia

F20.6 simple schizophrenia

F21 Schizotypal disorder

F22 Persistent delusional disorders

F23 Acute and transient psychotic disorders

F24 Induced delusional disorders

F25 Schizoaffective disorders

F30-F39 Mood (Affective) Disorders

F30 Manic episode

F31 Bipolar affective disorder

F32 Depressive episode

F33 Recurrent depressive disorder

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lated and Somatoform Disorders

F40 Phobic anxiety disorders

F41 Other anxiety disorders

F42 Obsessive-compulsive disorder

F43 Reaction to severe stress and adjustment disorders

F44 Dissociative (conversion) disorders

F45 Somatoform disorders

F50-F59 Behavioural Syndromes Associated with Physiological Disturbances and Physical Factors

F50 Eating disorders

F51 Non-organic sleep disorders

F52 Sexual dysfunction, not caused by organic disorder or disease

F60-F69 Disorders of Adult Personality and Behaviour

F60 Specific personality disorders

F60.0 paranoid personality disorder

F60.1 schizoid personality disorder

F60.2 dissocial personality disorder

F60.3 emotionally unstable personality disorder

F60.4 histrionic personality disorder

F60.5 anakastic personality disorder

F60.6 anxious personality disorder

F60.7 dependent personality disorder

F61 Mixed and other personality disorders

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sonality changes, not attributable to brain damage

F63 Habit and impulse disorders

F64 Gender identity disorders

F65 Disorders of sexual preference

F70-F79 Mental Retardation

F70 Mild mental retardation

F71 Moderate mental retardation

F72 Severe mental retardation

F73 Profound mental retardation

F80-F89 Disorders of Psychological Development

F80 Specific development disorders of speech and language

F81 Specific development disorders of scholastic skills

F82 Specific development disorders of motor function

F83 Mixed specific development disorders

F84 Pervasive development disorders

F90-F98 Behavioural and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence

F90 Hyperkinetic disorders

F91 Conduct disorders

F93 Emotional disorders with onset specific to childhood

F94 Disorders of social functioning with onset specific to childhood and adolescence

F95 Tic disorders

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

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...der

... Statistical Manual of Mental disorders) – 1994

This is the classification of mental disorders by the American Psychiatric Association (APA). The pattern adopted by DSMIV is of multiaxial systems.

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

The five axes of DSMIV *are:*

AXIS I: Clinical psychiatric diagnosis

AXIS II: Personality disorder and mental retardation

AXIS III: General medical conditions

AXIS IV: Psychosocial and environmental problems

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

Differences Between ICD10 and DSMIV		
	ICD10	**DSMIV**
Origin	International	American Psychiatric Association
Presentation	Different versions for clinical Work, research and primary care	A single version
Language	Available in all widely Spoken languages	English version only
Structure	Single axis	Multiaxial
Content	Diagnostic criteria do not include social consequences of the disorder	Diagnostic criteria usually include occupational or other areas of functioning

3.2 Group II Classification of Psychiatric Disorders

Psychiatric disorders, including mental subnormality (formerly known as mental deficiency) can be classified into the following three broad groupings:

(1) Mental subnormality
(2) Neuroses (Psychoneuroses)
(3) Psychoses

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normality (Old name, Mental Deficiency)

This term refers essentially to a subnormality of the intellect, as opposed to an abnormality in any other direction and implies that such subnormality has been present from birth to early age. In this last respect, it differs from conditions of intellectual impairment which have been acquired in later life, which can be irreversible or progressive, such as dementia.

While being in a class of their own, mental subnormal patients can manifest psychotic and neurotic symptoms and abnormalities of personality are common.

Examples of Mental Subnormality

(a) Idiot)

(b) Imbecile) Subnormal

(c) Feeble Minded)

(d) Dullness) Severely subnormal

Causes

(i) Genetic basis

(ii) Biochemical abnormality

(iii) Brain damage (in many cases)

(iv) At times unknown; but will probably also turn out to have some essential organic cause.

3.2.2 Psychoneuroses (or Neuroses)

Psychoneuroses (or Neuroses) are minor forms of psychiatric disorders. Generally speaking, the neuroses are those disorders in which the patientôs failure in adaptation is partial rather than complete. Often the patient seeks help because he feels he is ill. It is unusual for neurotic disorders to become so severe that continuation of life in the community becomes impossible or that the patient becomes a danger to himself or others.

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(b) Obsessional Neurosis

(c) Hysterical Neurosis

(d) Phobic Neurosis

Causes

(i) Emotional conflict

(ii) Maladjustment to life situations

(iii) Genetic and constitutional factors may contribute

3.2.3 Psychotic Disorders

Psychoses are major forms of Psychiatric disorders. Psychiatric conditions can be divided into:

Organic psychoses

An organic mental disorder is usually considered to be the one which can be found ï during life, clinical evidence of disease or damage to the brain; or after death, demonstrable changes in cerebral structure. However, even though no structural change can be demonstrated, there are some disorders where the cause is some interference with the physical functioning of the brain.

Functional psychoses

The term ñfunctionalò, however, is generally applied to conditions where the cause is not due to some known physical disorder though in such cases it cannot always be assumed that the origin is psychological in nature.

The functional psychoses can be divided into two main groups:

(a) The manic-depressive disorders
(b) Schizophrenic reaction types.

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epressive disorders

The manic depressive disorders are a group of ñmajor affective disordersò characterized by severe disturbances of mood ï elation or depression, far beyond the range of normal mood swings - that dominate the mental life of the patient. They are classified as manic type, depressed type, or circular type. Individuals who have depressions only are said to have ñbipolar Iò affective illness, while those who also have manic states have ñbipolar IIò affective illness.

Examples of manic depressive disorders

(1) Depressive illness

(2) Manic illness

(3) Involutional melancholia (or depression)

(4) Manic-depressive illness.

(b) Schizophrenic Reaction Illness

Schizophrenic disorders are amongst the commonest of Psychiatric disorders. Schizophrenia means splitting of the personality. Schizophrenia is a syndrome in which are found specific psychological manifestations recognize clinically, occurring in younger age groups and commonly leading to disintegration of the personality. The Schizophrenic has peculiar ways of thinking and behaving and perceives his environment in an abnormal way.

Examples of Schizophrenia

(1) Simple Schizophrenia

(2) Catatonic Schizophrenia

(3) Paranoid Schizophrenia

(4) Hebephrenic Schizophrenia

Note

The term ñorganic mental disorderò denotes psychologic and behavioural abnormalities resulting from transient or permanent cerebral dysfunction. Organic mental disorders are distinguished from functional disorders such as Schizophrenia and affective illness in that they have

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physiologic mechanisms; whereas the

4.0 CONCLUSION

Psychiatric illness is particularly difficult to classify, for it is the whole person and not a local part which is disordered. The arrangement of things into groups or categories is necessary for the formulation of our ideas and for their communication to others. Categories are not facts but man-made divisions created for convenience and are of value as long as they serve a useful purpose. Classification of illness is therefore useful in so far as it helps to classify ideas about the nature of the disorder and to aid its treatment.

5.0 SUMMARY

The learners have been taken through the two different ways of classifying mental disorders i.e. what we can refer to as modern and old ways of classification. Hopefully, the learners have had a good study.

6.0 TUTOR-MARKED ASSIGNMENT

Differentiate between the modern and old ways of classifying mental disorders.

7.0 REFERENCES/FURTHER READING

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SS AND MENTAL HEALTH

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1.0 INTRODUCTION

In the previous unit, we discussed the factors that influence mental health. Stress was mentioned as a sub-factor under psychological environment. This is because stress is very often generated within the human environment as well as his external environment. This unit will focus on the concept of stress, the different types of stress, the relationship between stress and frustration and manôs attempt and need to cope with or adapt to stress.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- define stress, stressor and emotional stress
- explain the meaning of ñstress generated by the social system as well as life eventsò
- state the differences between externally and internally generated stress.

3.0 MAIN CONTENT

3.1 Stress - Introduction

Stress is believed to be a universal phenomenon in the sense that we are all experiencing stress in one form or another; most times some are mild

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r stepping into a hall full of expectant ng into the class full of expectant students, a spectator jumping up and down in the stand urging his favourite football team to play harder; a bride about to be driven to the church, mosque, court to be married ï are all under stress.

Stress is not necessarily bad or negative to the mind or body. It can be motivating psychologically as well as physically in a positive way. Stress is thought to be largely responsible for most of mankindôs successes and achievements, since it is stress causing dissatisfaction or discomfort that pushes man to find solutions to his problems.

3.2 Definition of Stress

Stress has been defined as the non-specific response of the body to any demand (Selye,1978). In other words, such demand whether pleasant or otherwise, expects the body to respond to it through some kind of adaptation. Selye (1978) describes this response as the General Adaptation Syndrome (GAS). Selye further explains that the GAS operates in three stages. The first stage is the alarm reaction which is a generalized demand on the bodyôs defenses when the body is confronted with a stressor. A *stressor* is any force or factor that causes stress. It could be fear, anxiety, disease etc.

The second stage is resistance which is a form of adaptation to threat, for no organisms can survive under a perpetual state of alarm. The third stage is exhaustion. This is a state at which there is a wearing down of the organism. In analyzing the GAS, Selye says the syndrome is general ñbecause it is caused by agents which have a general effect upon large portions of the body, adaptive because it stimulates body defenses and thereby helps the organism to cope with stressò.

3.3 Types of Stress

We said earlier that a demand made by stress on the body may be pleasant or unpleasant. This implies that there are two types of stresses. The kind that acts as a threat to the fulfillment of basic human needs or to the effective functioning of the nervous system including homeostasis is referred to as *distress*. In other words, stress that causes negative or harmful response is distress. On the other hand, stress that leads to positive and constructive response is known as *eustress.* This type of stress can be both motivating and strengthening. The positiveness of stress is not often acknowledged nor noticed because it is harmful.

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This is any force or phenomenon that is capable of producing stress. It may be emotional conflict, fears, anxiety, fatigue, physical injury, disease, germs, poison, radiation, joyful incident etc. In other words, a stressor could be physical, biological or psychological. It could produce distress or eustress. The magnitude of a stress is dependent on the magnitude or intensity of the stressor.

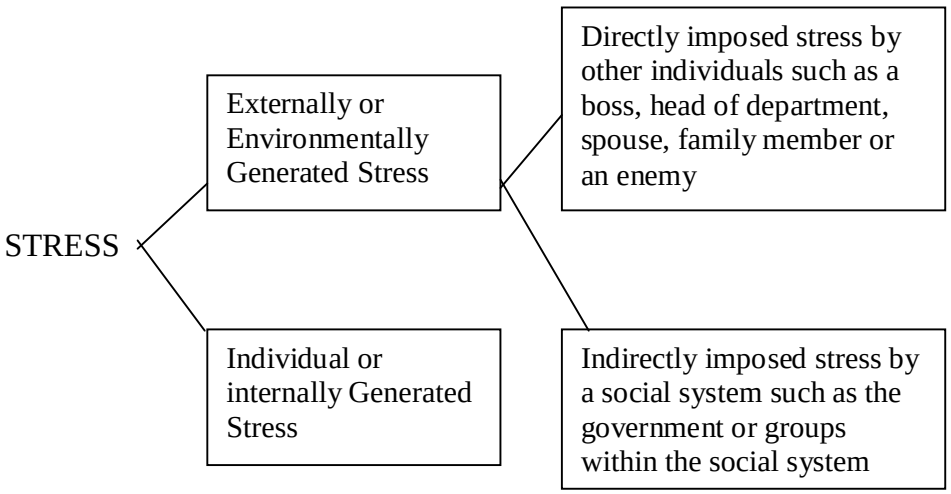
Emotional stress

This is a condition which involves tension, conflict or frustration often manifesting itself in emotional reaction. Anxiety may or may not be present for a condition to generate emotional stress. A personôs behaviour depends on how he responds to the stress which impinges on him. Everyone encounters a considerable number of stresses in everyday life and everyone has to learn to reduce the stresses by either changing something in the environment which causes such stresses or change something about him/herself which tends to act as stimulus to stress.

3.4 Body Reaction to Stress

Externally and internally generated stress

Stress can be externally generated; that is from a personôs environment, or it can be generated internally, that is from the individual himself. Externally (environment) generated stress can either be directly imposed by other individuals or indirectly imposed by a social system or groups or institutions within the social system such as the government and its agencies.



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...ake a favourable impact on his lecturer ...irst encounter with his lecturer may ...t he becomes emotionally disturbed. This is a case of directly imposed environmental stress. So also is the activity of a car snatcher. On the other hand, a mass retrenchment of workers by an establishment, company or a government agency because of the government's structural adjustment programme (SAP), or the forced retirement of workers by the government on flimsy reasons are examples of an indirectly generated environment stress from the social system.

An intense personal ambition to succeed or to achieve an end can lead to internally generated stress, although such a stress may originate externally. For instance, a person who comes from a family of achievers and successful men and women may because of this external influence want desperately to become successful like the others. The person may then set a target for him/herself unconsciously and the inability to attain this set goal definitely results in internally generated stress.

There is no way or method to determine the degree of stress to which an individual is experiencing, nor how each individual would react to a given stress. Coping with stress is an individual problem. How an individual fares in the presence of stress depends not only his/her total make up, but also on the prevailing circumstances, the person's previous experience(s) and a host of other psychological factors.

It is generally agreed that everyone has an optimal threshold for stress beyond which it could cause very serious problems either physically or psychologically. It is because of this that stress must be kept in check. Keeping stress in check is most important because prolonged stress arising from frustration results in distress which is devastating to mental health.

In order to avoid the dangerous consequences of stress, we need to be aware of initial symptoms so as to be able to put them in check. Selye (1954) listed a number of stress signs which will help us recognize the presence of stress in our everyday life. These include:

1. General irritability, hyper-excitation or depression.
2. Pounding of the heart (which is an indicator of high blood pressure often caused by stress).
3. Dryness of the throat and mouth.
4. Impulsive behaviour, emotional instability.
5. The over-powering urge to cry or run or hide.

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ncentrate.

reality, weakness or dizziness.

8. Fatigue, loss of joie de vivre.
9. Free-floating anxiety (feeling fear without knowing the cause).
10. Emotional tension and alertness, being keyed up.
11. Trembling, nervous ticks.
12. Tendency to be easily startled by small sounds.
13. High-pitched, nervous laughter.
14. Stuttering and other speech difficulties.
15. Grinding of the teeth.
16. Insomnia.
17. Hyper-mobility (inability to keep still).
18. Sweating.
19. Frequent need to urinate.
20. Migraine headaches.
21. Pre-menstrual tension or missed menstrual cycle.
22. Pain in the neck or lower back.
23. Loss of or excessive appetite.
24. Increased smoking (by smokers).
25. Increased use of legally prescribed drugs such as tranquilizers.
26. Nightmares.
27. Accident proneness.

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...easiness in stomach and sometimes ...ed gastrointestinal functions that can ...erative colitis).

According to Hans Seyle, people respond differently to general demands depending upon their conditioning. When these specific symptoms appear, it is time to stop or do things differently through a worthwhile diversion, he advised. Can you associate any of these symptoms with stressful events in your own life? If you have experienced these signs, then you need to watch out and take necessary precaution.

3.5 Relationship between Motivation, Frustration and Stress

Basic human needs (organic needs, security needs, needs for love, self-esteem and self-actualisation) and personality (determined by heredity, environment, learned coping methods and interpretation) create motivation. Motivation is the underlying factor which impels human behaviour and which gives direction for human actions towards the fulfillment of his desires or satisfaction of his needs. When the fulfillment of desire or satisfaction of needs is blocked, frustration results. This in turn generates stress. In other words, an action which is denied by an obstacle which lies between a need and its fulfillment leads to frustration. The failure to find a misplaced article; trying to kill a rat and tripping; wanting to buy a new pair of shoes urgently and not finding money for the purchase, are instances of unfulfilled need and are therefore sources of frustration.

There are basically 3 types of frustration:

- the type generated by the environment, such as falling over an object and getting hurt or a loud continuous noise that disturbs an attempt to sleep.

- the type generated from within an individual such as failing to make the school/college team, or failing to beat the deadline.

- the type generated by conflict such as a desire to steal something one wants badly, but afraid of being caught and disgraced.

All these desires are thwarted and motivated by the desire to satisfy some need. The failure to satisfy the need breeds frustration and the frustration creates stress which is so detrimental to health, depending on the magnitude of the stress and how well the victim can cope or adapt.

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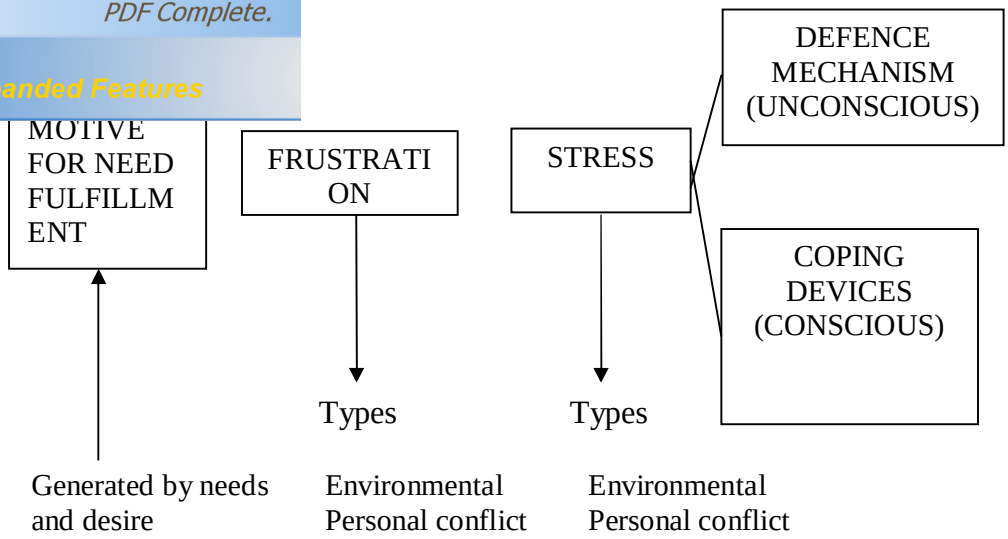

Chain Reaction of Blocked Motive

3.6 Stress, Health and Illness

In the Nigerian society, a premium is increasingly being placed on achievement, competition and wealth and this has created a climate that is conducive to stress. In addition to this, considerable stress is generated by life events as well as the general economic situation causing general inflation with the consequent high cost of items such as food for the satisfaction of basic needs. But less obvious are probably events in our lives which we take for granted, but which may in fact induce stress without us being aware of them until their consequences are felt.

Think of the various life events that have generated stress, like traveling to a strange town or place; going for an interview; picking up a new job; getting married; noise pollution and working at a job one dislikes. All these create a conducive climate for stress which may lead to a number of stress related illnesses such as gastric ulcer, asthma, high blood pressure and migraine headache. Other conditions are tuberculosis, thyroid disease and diabetes which may also be influenced by various life stresses (Warren Johnson, 1977).

You will observe that with the use of the óSocial Readjustment Rating Scaleô by Holmes and Rahe that most of the items regarded as stress events are related to family life. This does not imply the avoidance of marriage and parenthood. It is true that the family life entails considerable stress, but bereavement, separation, arguments, dependency, loss of status, loss of job or income etc. are quite familiar to those who have experienced them. These events will continue to occur to people. Everyone should work towards becoming familiar with

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for coping with life events generated

Rank	Life Event	Mean Value
1.	Death of spouse	100
2.	Divorce	73
3.	Marital Separation	65
4.	Jail term	63
5.	Death of close family member	63
6.	Personal injury or illness	53
7.	Marriage	50
8.	Fired or sacked from work	47
9.	Marital reconciliation	45
10.	Retirement	45
11.	Change in health of family member	44
12.	Pregnancy	40
13.	Sex difficulties	39
14.	Gain of new family member	39
15.	Business re-adjustment	39
16.	Change of financial state	38
17.	Death of close friend	37
18.	Change to different line or work	36
19.	Change in number of arguments with spouse	35
20.	Mortgage over ₦185, 000	31
21.	Fore -closure of mortgage or loan	30

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	ponsibility at work	29
	ter leaving home	29
24.	Trouble with in-laws	29
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26.	Wife (or husband) begins or stops work	26
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35.	Change in church (religious) activities	19
36.	Change in social activities	18
37.	Mortgage or loan less than ₦185, 000	17
38.	Change in sleeping habits	16
39.	Change in number of family get-together	15
40.	Change in eating habits	15
41.	Vacation	13
42.	Christmas (festive occasion)	12
43.	Minor violations of the law	11

Social Readjustment Rating Scale

Source: T.H. Holmes and R.H. Rahe (1967), *Journal of Psychosomatic Research,* LL 2156.

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...arious events in terms of stress in your ...e values obtained by Holmes and ... that have happened in your life over the past twelve months. If you have a rating scale of 300 or more, it is almost an 80% chance that you will get sick in the near future; with 150-299 rating get scale, there is 50% chance that you will get sick in the near future and with less than 150, the chance is 30%.

This test could be a useful guide to determine a clientsô or even your stress level. If your score goes up, you must take steps to reduce the level of stress in your life; with the hope of reducing the chance of exceeding your stress, tolerance, physical or mental (Warren Johnson, 1977).

3.7 Effects of Stress

There is considerable agreement among most researchers that stress contributes to the incidence of diseases as well as their seriousness. What has been very confusing is that some people become ill while others subjected to a similar stressful event are not. A theory that explains the difference suggests that every one of us has only so much energy to devote to his wellbeing and that when we channel a large proportion of this energy into coping with reactions of our body; it leaves us a small portion to defend the body against disease. This means that the ability of the body to cope with the stressor within the environment is seriously depleted when there is a too frequent summoning of the stress-reaction of the body (La Place, 1987). As a consequence, many people become ill when they cope with crisis or in some cases deal with a series of ordinary life events.

It has not been generally agreed that specific diseases are actually caused by stress, but certain diseases have long been associated with stress. These include peptic ulcers, hypertension, migraine headaches and depression.

Migraine headache is a severe throbbing pain in the head caused by constriction of the arteries supplying blood to a part of the head. Symptoms are distorted vision, nausea and vomiting. Depression is a passive response to stress manifested by sadness, hopelessness, withdrawal, isolation, feeling of worthlessness and apathy.

Stress and Suicide

All suicide attempts are thought to result from depression and the victimôs search for some means or ways to end it all. It is believed that four out of every five suicide attempts are a result of depression-a

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stress (La Place, 1987). Attempters of suicide leave hich should alert significant others to the possibility t exists: chronic depression; alcoholism; loners with no supportive family network or friends; persons alienated from others for various reasons; those facing specific stressful life events such as loss of job, loss of spouse, serious illness etc.

Also people attempting suicide discuss their plans: advantages and disadvantages of certain methods of death; what they wish to have accomplished or done with their property when they die; the setting in which they wish to die. These hints should be taken quite seriously. You should not make the issue lightly but listen attentively and let him/her understand there is more to living and that you really acre; remind him/her that there are other choices other than death. Try to reassure him/her that whatever the cause of his contemplated suicide, it is not permanent but will pass away.

4.0 CONCLUSION

Much as we decry stress which we know is unavoidable, it is not always harmful. It can be beneficial. Stress that arouses negative tensions in our body is referred to as distress, and the one that arouses positive response is termed eustress. Stress according to Hans Selye, is the non-specific response which the body makes to any demand. The cause of stress is called a stressor. Whenever the body is subjected to any stress, it undergoes a complex series of physiological reactions which prepare the individual for fight or flight. The response to stress in almost every case is manifested in physical action. When this reaction is frequently evoked, the body can be damaged or worn down and resistance to disease is weakened. Causes of stress in the society are numerous, but some are not always obvious. A crowded, noisy and polluted town may be easily recognized as a source of stress, but job situation, getting married, loss of a significant one or overwhelming desire to succeed may not be seen as sources of stress. Although the casual relationship between stress and diseases has not been fully established, there is a general agreement that stress is capable of heightening the course of disease once a disease is present. However, it is widely acknowledged that stress can lead to hypertension and disorders such as migraine headache and depression. Stress can be self-induced, that is generated internally; it can be generated externally or environmentally; it can be generated by small or large social systems.

5.0 SUMMARY

In this unit, we have gone through what stress is, its nature, how stress is generated both internally and externally, how body reacts to stress,

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frustration and stress, relationship of
s of stress.

6.0 TUTOR-MARKED ASSIGNMENT

1. Explain the relationship between motivation, frustration and stress.
2. How is stress generated both internally and externally?

7.0 REFERENCES/FURTHER READING

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ONALITY DISORDERS

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  3.4 Antisocial Personality Disturbances
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1.0 INTRODUCTION

This unit will expose the learners to personality disorders. A personôs character structure is reflected in the habitual attitudes and reaction patterns he displays in human relationships. Personality or character disorders consist of inappropriate exaggeration of one or more aspects of behaviour. Lifelong patterns of action and behaviour rather than specifically identifiable mental or emotional symptoms characterize the personality disorders.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- identify personality trait disturbances
- explain the personality pattern disturbances
- discuss the antisocial personality disturbances
- describe the psychopathic personalities
- explain juvenile delinquency.

3.0 MAIN CONTENT

3.1 Personality Disorders

A personôs character structure is reflected in the habitual attitudes and reaction patterns he displays in human relationships. Personality or character disorders consist of inappropriate exaggeration of one or more aspects of behaviour. Lifelong patterns of action and behaviour rather

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al or emotional symptoms characterize

3.2 Personality Trait Disturbances

Patients with these disorders are unable to maintain their emotional equilibrium and independence under stress because of emotional maldevelopment. There are three types:

(i) Emotional unstable personalities

These persons show poor judgment under stress and their relationships with other people are characterized by flunctuating emotional attitudes with poorly controlled hostility, guilt and anxiety.

(ii) Passive- aggressive personalities

These persons tend to be helpless and indecisive or react to frustration by irritability, throw tantrums and destructive behaviour. They tend to establish relationships of the child-parent type, showing either excessive dependency upon or control over others.

(iii) Compulsive personalities

Compulsive personalities display chronic excessive or abusive concern, with strict adherence to high standards of conscience and conformity. They are usually rigid, overly conscientious and hard-working and are unable to feel free of tension.

3.3 Personality Pattern Disturbances

These disorders are more deeply seated than the personality trait disturbances and are usually even more refractory to therapy.

(i) Inadequate personalities

These persons show poor judgment, inadaptability, ineptness and social incompatibility. Although they have no gross physical or mental deficit, they respond inadequately to intellectual emotional, social and physical demands.

(ii) Schizoid personalities

Schizoid personalities avoid close interpersonal relationships, lack aggressiveness and are unable to display hostility. Their thinking is autistic and they are usually described as quiet, shy, obedient, sensitive

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uals. Peculiar or ñoffbeatò ideas and behaviour are

(iii) Cyclothymic personalities

Individuals in this group fluctuate between elation and sadness without obvious relation to external events.

(iv) Paranoid personalities

These persons are similar to the schizoid types, but they also show suspiciousness, envy, extreme jealousy and stubbornness.

3.4 Antisocial Personality Disturbances

The antisocial personality usually has a lifelong history of conflict with the customs and laws of Society. This group of disorders must be differentiated from other severe personality disorders, neuroses psychoses and organic brain disease, which may also be characterized by failure to conform to prevailing cultural and legal norms.

(i) Antisocial personality

Individual in this group chronically in trouble with society and do not benefit from punishment or experience. They are often chronic liars and emotionally immature, with poor judgement and no sense of responsibility. They may present a likable, pleasant appearance and tend to rationalize their behaviour. Former terms for these individuals are ñPsychopathsò, ñPsychopathic Personalitiesò and ñConstitutional Psychopathic inferiorsò.

(ii) Dyssocial personality

Persons in this group, because of prolonged life in an abnormal environment disregard the usual social codes. They may, however, show strong loyalties among themselves.

(iii) Sexual deviation

The sexual deviants exhibit sexual behaviour contrary to accepted cultural codes and customs.

Similar symptoms may occur with schizophrenia, the psychoneurosis or senile psychosis, so that these disorders must be ruled out. Some of the more common deviations are the following: (Combination of these sexual deviations may occur):

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...ps with persons of the same sex.

(b) Fetishism

Substitution of some object (e.g. shoe, garment) for the genitals

(c) Transvestism

Sexual pleasure obtained from wearing the clothing of the opposite sex.

(d) Voyeurism

Sexual pleasure obtained from observation of exposed genitals or the sexual activity of others.

(e) Bestiality

Sexual relations with animals.

(f) Pederasty

Anal intercourse with boys.

(g) Sadism

Sexual pleasure derived from acts of cruelty to others. Sexual activity may occur concurrently.

(h) Masochism

Sexual pleasure derived from experiencing pain; or humiliation.

(iv) Addiction

Alcohol addiction is common among people with personality or character disorders and may also occur in many types of Psychosis and neurosis. During periods of intoxication the patient may have increased feelings of importance. Following an acute alcoholic bouts, however, he usually feels consideration self-blame and self-contempt.

Narcotic addicts generally show neurotic or psychopathic backgrounds with excessive emotional dependence upon others. Addicts are apt to use any means, legal or illegal, to obtain the funds necessary to secure their addicting drug.

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Personalities

A Psychopathic personality is selfish and lacks foresight and feelings for others. He is unable to profit from past experience. He cannot plan ahead realistically or sees the consequences of his actions. He is impulsive like a small child, and cannot control his whims as other people do. He feels little or no sense of responsibility, of right and wrong, or remorse for what he does. Neither punishment nor kindly treatment appears to alter him. He is impulsive and liable to explosive outbursts of violence. With other people he is continually demanding rarely giving anything in return.

He seems to be incapable of any deep emotional feeling for others. Not expectedly, the psychopath sometimes comes into conflict with society. Perhaps because female psychopathic personalities are less likely to break the law and draw attention to themselves, psychopathy is considered to be more common among men.

Types of Psychopath

Psychopaths are described as inadequate or aggressive on the basis of their behaviour. They are also sometimes described in terms of their main personality features, like Schizoid, hysterical, obsessive or cyclothymic.

The inadequate psychopath

Lacks persistence and cannot stand on his own. He never stays in a job for long, and becomes bored and depressed by routine. Everyone also is held to blame for his misfortunes, never himself. Often he possesses considerable charm and he is able to enlist sympathy and help from those he meets; but anyone trying to help him is likely to find himself drained dry of money and emotion.

The aggressive psychopath

‘Acts outô his impulses. Explosive outbursts of anger occur, often for little or no reason. Anger may be so intense that ñClouding of Consciousnessò occurs and what little self-control he has lost. Brutal assaults and murders have been committed at these times.

Such an outburst clears the air and for a time the Psychopath may feel relaxed and cheerful, but sooner or later tension increases. Sexual assaults and serious offences may occur.

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1. Genetic. Psychopathic disorders tend to run in families.

2. Brain damage.

3. Environmental factors.

Treatment

(a) Treatment is difficult and regarded by some as ineffective. A patient may refuse treatment on the grounds that he is not ill.

(b) Admission of Patient ï especially if condition is very serious.

(c) When psychopathy seems to be due predominantly to brain damage, neuro-surgery can be considered, i.e. temporal lobectomy.

(d) Drugs are occasionally useful. Minor tranquillisers lessen explosive outbursts, sexual outbursts can sometimes be controlled with stilboestrol.

(e) Psychotherapy.

(f) Nursing care ï These patients are amongst the most difficult to nurse. They resent the nurse because of the authority she represents.

In order to nurse psychopathic patients with any degree of success, it is essential that the nurse is aware of their personality deficiencies. The best attitude to adopt from the nursesô point of view and in the interests of her patient, is one of friendly firmness.

SELF ASSESSMENT EXERCISE

Discuss together the difference between the Inadequate and aggressive psychopaths

4.0 CONCLUSION

This unit has looked into personality disorders such as personality trait disturbances, personality pattern disturbances, antisocial personality disturbances, psychopathic personalities, juvenile delinquency, exhibitionism and homosexuality.

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The learners have been exposed to various personality disorders which are fundamental to mental illness. We do hope the unit has increased your knowledge in the field of mental health and mental illness.

6.0 TUTOR-MARKED ASSIGNMENT

1. Briefly discuss the antisocial personality disturbances.
2. How can the rate of juvenile delinquency be reduced in Nigerian Society?

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EMERGENCIES

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1.0 INTRODUCTION

This unit will expose the learners to a number of psychiatric emergency in which the patient requires immediate intervention.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- list some psychiatric emergencies
- describe five of the identified psychiatric emergencies
- explain the organic psychiatric emergencies.

3.0 MAIN CONTENT

3.1 Introduction – Psychiatric Emergencies

Psychiatric emergency is a condition wherein the patient has disturbances of thought, affect and psychomotor activity leading to a threat to his existence (suicide), or threat to the people in the environment (homicide). This condition needs immediate intervention to

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f the patient, bring down the anxiety of the family nce emotional/physical security to others in the

3.2 Common Psychiatric Emergencies

3.2.1 Suicidal Attempt

In psychiatry a suicidal attempt is considered to be one of the commonest emergencies. Suicide is a type of deliberate self-harm and is defined as an intentional human act of killing oneself.

Etiology

The following are some of the possible causes of suicide:

- Psychiatric Disorders
- Major depression
- Schizophrenia
- Drug or alcohol abuse
- Dementia
- Delirium
- Personality disorder
- Patients with incurable or painful physical disorders like cancer and AIDS.

Psychological factors

- Failure in examination
- Dowry difficulties
- Marital difficulties
- Loss of loved ones/object
- Isolation and alienation from social groups
- Financial and occupational difficulties.

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- Age
  - males above 40 years of age
  - females above 55 years of age
- Sex
  - men have greater risk of completed suicide
  - suicide is 3 times more common in men than women
  - women have higher rate of attempted suicide
- Being unmarried, divorced, widowed or separated
- Having a definite suicidal plan
- History of previous suicidal attempts
- Recent losses.

Management

1. Be aware of certain signs which may indicate that the individual may commit suicide, such as:

- suicide threat
- writing farewell letters
- giving away treasured articles
- making a Will
- closing bank accounts
- appearing peaceful and happy after a period of depression
- refusing to eat or drink, maintain personal hygiene.

2. Monitoring the patientôs safety needs:

- take all suicidal threats or attempts seriously and notify a psychiatrist

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ic agents such as drugs/alcohol

- he drug tray within reach of the patient, make sure that the daily medication is swallowed
- remove sharp instruments such as razor blades, knives, glass bottles
- remove straps and clothing such as belts, neckties
- do not allow the patient to bolt his door on the inside, make sure that somebody accompanies him to the bathroom
- patient should be kept in constant observation and should never be left alone
- have good vigilance especially during morning hours
- spend time with him, talk to him, and allow him to ventilate his feelings
- encourage him to talk about his suicidal plans/methods
- if suicidal tendencies are very severe, sedation should be given as prescribed.

3. Encourage verbal communication of suicidal ideas as well as his/her fear and depressive thoughts. A óno suicidalô pact may be signed, which is a written agreement between the patients and the nurse, that client will not act on suicidal impulses, but will approach the nurse to talk about them.

4. Enhance self-esteem of the patient by focusing on his strengths rather than weaknesses. His positive qualities should be emphasized with realistic praise and appreciation. This fosters a sense of self-worth and enables him to take control of his life situation.

3.2.2 Violent, Aggressive Behaviour and Excitement

This is a severe form of aggressiveness. During this stage, patient will be irrational, uncooperative, delusional and assaultive.

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- Organic psychiatric disorders like delirium, dementia, Wernicke-Korsakoffôs psychosis.

- Other psychiatric disorders like schizophrenia, mania, agitated depression, withdrawal from alcohol and drugs, epilepsy, acute stress reaction, panic disorder and personality disorders.

Management

- An excited patient is usually brought tied up with a rope or in chains. The first step should be to remove he chains.
- Talk to the patient and see if he responds. Firm and kind approach by the nurse is essential.
- Usually sedation is given. Common drugs used are: diazepam 10-20mg, IV; haloperidol 10-20mg; chlorpromazine 50-100mg IM.
- Once the patient is sedated, take careful history from relatives; rule out the possibility of organic pathology. In particular check for history of convulsions, fever, recent intake of alcohol, flunctuations of consciousness.
- Carry out complete physical examinations.
- Send blood specimens for hemoglobin, total cell count etc.
- Look for evidence of dehydration and malnutrition. If there is severe dehydration, glucose saline drip may be started.
- Have less furniture in the room and remove sharp instruments, ropes, glass items, ties, strings, match boxes, etc from patientôs vicinity.
- Keep environmental stimuli, such as lighting and noise levels to a minimum; assign single room; limit interactions with others.
- Remove hazardous objects and substances; caution the patient when there is possibility of an accident.
- Stay with the patient as hyperactivity increases to reduce anxiety level and foster a feeling of security.
- Redirect violent behaviour with physical outlets such as exercise, outdoor activities.
- Encourage the patient to ótalk outô his aggressive feelings, rather than acting them out.
- If the patient is not calmed by talking down and refuses medications, restraints may become necessary.
- Following application of restraints, observe patient every 15 minutes to ensure that nutritional and elimination needs are met. Also observe for any numbness, tingling or cyanosis in the extremities. It is important to choose the least restrictive alternative as far as possible for these patients.

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or self-protection when handling an aggressive

- never see a potentially violent person alone
- keep a comfortable distance away from the patient (arm length)
- be prepared to move, a violent patient can strike out suddenly
- maintain a clear exit route for both the staff and patient
- be sure that the patient has no weapons in his possession before approaching him
- if patient is having a weapon ask him to keep it on a table or floor rather than fighting with him to take it away
- keep something like a pillow, mattress or blanket wrapped around arm between you and the weapon
- distract the patient momentarily to remove the weapon (throwing water in the patientôs face, yelling etc)
- give prescribed antipsychotic medications.

3.2.3 Panic Attacks

Episode of acute anxiety and panic can occur as a part of psychotic or neurotic illness. The patient will experience palpitations, sweating, tremors, feelings of choking, chest pain, nausea, abdominal distress, fear of dying, paresthesias, chills or hot flushes.

Management

- Give reassurance first.
- Search for causes.
- Diazepam 10mg or Lorazepam 2mg may be administered.

3.2.4 Stupor and Catatonic Syndrome

Stupor is a clinical syndrome of alkinesis and mutism but with relevant preservation of conscious awareness. Stupor is often associated with catatonic signs and symptoms (catatonic withdrawal or catatonic stupor). The various catatonic signs include mutism, negativism, stupor,

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xia, automatic obedience, posturing,

Management

- Ensure patent airway.
- Administer I. V. fluids.
- Collect history and perform physical examination.
- Draw blood for investigations before starting any treatment.
- Other care is same as that for an unconscious patient.

3.2.5 Hysterical Attacks

A hysteric may mimic abnormality of any function, which is under voluntary control. The common modes of presentation may be:

- Hysterical fits
- Hysterical ataxia
- Hysterical paraplegia

All presentations are marked by a dramatic quality and sadness of mood.

Management

- Hysterical fit must be distinguished from genuine fits.
- As hysterical symptoms can cause panic among relatives, explain to the relatives the psychological nature of symptoms. Reassure that no harm would come to the patient.
- Help the patient to realize the meaning of the symptoms and help him find alternative ways of coping with stress.
- Suggestion therapy with I.V Pentothal may be helpful in some cases.

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ituational Disturbances

These are characterized by disturbed feelings and behaviour occurring due to overwhelming external stimuli.

Management

- Reassurance
- Mild sedation if necessary
- Allowing the patient to ventilate his/her feelings
- Counseling by an understanding professional.

3.3 Organic Psychiatric Emergencies

3.3.1 Delirium Tremens

Delirium tremens is an acute condition resulting from alcohol withdrawal from alcohol.

Management

- Keep the patient in a quiet and safe environment.
- Sedation is usually given with diazepam 10mg or Lorazepam 4mg IV, followed by oral administration.
- Maintain fluid and electrolyte balance.
- Reassure patient and family.

3.3.2 Epileptic Furor

Following epileptic attack patient may behave in a strange manner and become excited and violent:

Management

- Sedation: Inj. Diazepam 10mg IV [or] Inj. Luminal 10mg I. V. followed by oral anti-convulsants.
- Haloperidol 10mg I. V. helps to reduce psychotic behaviour.

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trapyramidal Syndrome

Antipsychotics can cause a variety of movement related side-effects, collectively known as extrapyramidal symptoms (EPS). Neuroleptic malignant syndrome is rare but most serious of these symptoms and occurs in a small minority of patients taking neuroleptics, especially high-potency compounds.

Management

The drug should be stopped immediately. Treatment is symptomatic and includes cooling the patient, maintaining fluid and electrolyte balance and treating intercurrent infections. Diazepam can be used for muscle stiffness. Dantrolene, a drug used to treat malignant hyperthermia, bromocriptine, amantadine and L-dopa have been used.

3.3.4 Drug Toxicity

Drug over-dosage may be accidental or suicidal. In either case all attempts must be made to find out the drug consumed. A detailed history should be collected and symptomatic treatment instituted.

A common case of drug poisoning is lithium toxicity. The symptoms include drowsiness, vomiting, abdominal pain, confusion, blurred vision, acute circulatory failure, stupor and coma, generalized convulsions, oliguria and death.

Management

- Administer Oxygen
- Start I.V line.
- Assess for cardiac arrhythmias.
- Refer for haemidialysis.
- Administer anticonvulsants.

4.0 CONCLUSION

Both common psychiatric emergencies and organic psychiatric emergencies are subjects of concern to both the mental health service providers, the family members and the society at large. So adequate understanding and pragmatic approach of the service providers will go a log way in assisting the affected individuals.

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The unit has taken the learners through both common and organic psychiatric emergencies and it is our hope that the knowledge of the learners have been enhanced.

6.0 TUTOR-MARKED ASSIGNMENT

Differentiate between common psychiatric emergencies and organic psychiatric emergencies.

7.0 REFERENCES/FURTHER READING

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CHILDHOOD PSYCHIATRY I

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1.0 INTRODUCTION

The next three units will expose the learners to a field of child psychiatry which is new to the twentieth century. This unit will cover the classification of childhood psychiatric disorders, mental retardation and disorders of psychological development.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- classify childhood psychiatric disorders
- explain the concept of mental retardation
- describe the care and rehabilitation of the mentally retarded
- list the disorders of psychological development.

3.0 MAIN CONTENT

3.1 Introduction

The field of child psychiatry is new to the twentieth century and child psychiatric nursing evolved gradually as the therapeutic value of nursesô relationships with children began to be realized. In 1954, the first graduate programme in child psychiatric nursing was opened. Advocates of Child Psychiatry (ACPN), the professional organization for this nursing specialty was established in 1971 and the first ANA certification of child psychiatric nurses took place in 1979. The ANAôs Standards of child and adolescent psychiatric and mental health nursing practice were published in 1985.

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c nurse uses a wide range of treatment modalities, erapy, behaviour modification, cognitive behaviour play, group and family therapy and pharmacological agents. Child psychiatric nursing is different from adult psychiatric nursing in the following ways:

- It is seldom that children initiate a consultation with the clinician. Instead, they are brought by adults, usually the parents, who think that some aspects of behaviour or development is abnormal.

- The childôs stage of development determines whether behaviour is normal or abnormal. For instance, bedwetting is normal at the age of 3 years but abnormal when the child is 7. Thus, greater attention should be paid to the stage of development of the child and the duration of the disorder.

- Children are generally less able to express themselves in words; therefore evidence of the disturbance is based more on the observations of behaviour made by parents, teachers and others.

- The treatment of children makes use of less medications or other method of individual treatment. Main emphasis is on changing the attitudes of parents, reassuring and retraining children, working with family and coordinating the efforts of others who can help children especially at school.

3.2 Classification

Mental retardation (F7)

Disorders of psychological development (F8)

- Specific developmental disorders of speech and language

- Specific developmental disorders of scholastic skills

- Specific developmental disorders of motor function

- Pervasive developmental disorders.

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ers with onset occurring in childhood

- Hyperkinetic disorders
- Conduct disorders
- Emotional disorders
  - Separation anxiety disorder of childhood
  - Phobic anxiety disorder of childhood
  - Social anxiety disorder of childhood
  - Sibling rivalry disorder
- Disorders of social functioning
  - Elective mutism
- Tic disorders
- Other behavioural and emotional disorders in childhood and adolescence
  - Non-organic enuresis
  - Non-organic encopresis
  - Feeding disorders of infancy and childhood
  - Stereotyped movement disorders
  - Stuttering

3.3 Mental Retardation

Definition

ñMental retardation refers to significantly subaverage general intellectual functioning resulting in or associated with concurrent impairments in adaptive behaviour and manifested during the developmental periodò (American Association on Mental Deficiency, 1983*).*

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al functioning" is defined as the result obtained by f standardized general intelligence tests developed for the purpose, and adopted to the conditions of the region/country.

"Significant subaverage" is defined as an Intelligence Quotient (IQ) of 70 or below on standardized measure of intelligence. The upper limit is intended as a guideline and could be extended to 75 or more, depending on the reliability of the intelligence test used.

"Adaptive behaviour" is defined as the degree with which the individual meets the standards of personal independence and social responsibility expected of his age and cultural group. The expectations of adaptive behaviour vary with the chronological age. The deficits in adaptive behaviour may be reflected in the following areas:

During infancy and childhood in:

- Sensory and motor skill development
- Communication skill (including speech and language)
- Self-help skills
- Socialization

During childhood and adolescence in:

- Application of basic academic skill to daily life activities
- Application of appropriate reasoning and judgment in the mastery of the environment
- Social skills

During late adolescence in:

- Vocational and social responsibilities and performance

"Developmental period" is defined as the period of time between conception and the 18th birthday.

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Chromosomal abnormalities

- Downôs syndrome
- Fragile X syndrome
- Trisomy X syndrome
- Cat-cry syndrome
- Prader-willi syndrome

Metabolic disorders

- Phenylketonuria
- Wilsonôs disease
- Galactosemia

Cranial malformation

- Hydrocephaly
- Microdephaly

Gross disease of brain

- Tuberculosis scleroses
- Neurofibromatosis
- Epilepsy

Prenatal Factors

Infections

- Rubella
- Cytomegalovirus
- Syphilis
- Toxoplasmosis, herpes simplex

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- Hypothyroidism
- Hyporarathyroidism
- Diabetes mellitus

Physical damage and disorders

- Injury
- Hypoxia
- Radiation
- Anemia
- Emphysema

Intoxication

- Lead
- Certain drugs
- Substance abuse

Placental dysfunction

- Toxemia of pregnancy
- Placenta previa
- Cord prolapsed
- Nutritional growth retardation

Perinatal Factors

- Birth asphyxia
- Prolonged or difficult birth
- Prematurity (due to complications)

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- Instrumental delivery (resulting on head injury, intraventricular hemorrhage)

Postnatal Factors

- Infections
  - Encephalitis
  - Measles
  - Meningitis
  - Septicemia
- Accidents
- Lead poisoning

Environmental and Sociocultural Factors

- Cultural deprivation
- Low socioeconomic status
- Inadequate caretakers
- Child abuse

Classification

Mental retardation is classified into the following levels based on the Intelligent quotient of individuals.

	Intelligent Quotient (IQ)
Mild (Educable)	50-70
Moderate (Trainable)	35-50
Severe (Dependent retarded)	20-35
Profound (Life support)	<20

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estations

Mild Retarded (I.Q.50-70)

This is commonest type of mental retardation accounting for 85 to 90 percent of all cases. These individuals have minimal retardation in sensory-motor areas. They often progress up to Primary 6 of formal education can achieve vocational and social self-sufficiency with a little support. They can develop social and communication skills, but have deficits in cognitive function like poor ability for abstraction and egocentric thinking.

Moderate Retardation (I.Q. 35-50)

About 10 percent of the mentally retarded come under this group. Communication skills develop much slowly in these individuals. They can be trained to support themselves by performing semiskilled or unskilled work under supervision.

Severe Retardation (I.Q. 20-35)

Severe mental retardation is often recognized early in life with poor motor development and absent or markedly delayed speech and communication skills. There is a possibility of teaching some skills in ADL skills with long-term consistent behaviour modification. But most of them require a great deal of assistance and structured living arrangements.

Profound Retardation (I.Q. <20)

This group account for 1 to 2 percent of all mentally retarded. The achievement of developmental milestones is markedly delayed. They require constant nursing care/supervision. Associated physical disorders are common.

Diagnosis

- History collection from parents and caretakers
- Physical examination
- Neurological examination
- Assessing milestones development
- Investigations

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...n for metabolic disorders

- ...iochemical studies
- amniocentesis in infant chromosomal disorders
- chorionic villi sampling

- Hearing and speech evaluation
- EEG, especially if seizures are present
- CT scan or MRI brain e.g. in tuberculosis
- Thyroid function tests when cretinism is suspected
- Psychological tests like Stanford Binet Intelligence Scale and Wechsler Intelligence Scale For Children (WISC), for categorizing the childôs disability

Through psychological testing, the childôs mental age is estimated. The Intelligence Quotient is then determined using the formula:

$$\frac{\text{Mental Age (M.A.)}}{\text{Chronological Age (C.A.)}} \times 100$$

Prognosis

The prognosis for children with mental retardation has improved and institutional care is no longer recommended. These children are mainstreamed whenever feasible and are taught survival skills. A multidimensional orientation is used when working with these children, considering their physiological, cognitive, social and emotional development.

Primary Prevention

Preconception

- Genetic counseling, which is an attempt to determine risk of occurrence or recurrence of specific genetic or chromosomal disorders; parents can then make an informed decision as to the risks of having a retarded child.

- Immunization for maternal rubella.

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aternal nutrition can lay a sound metabolic r later childbearing.

- Family planning in terms of size, appropriate spacing and age of parents can also affect a variety of specific causal agents.

During Gestation

Two general approaches to prevention are associated with this period:

a. Prenatal care

b. Analysis of fetus for possible genetic disorders.

a. Prenatal care

- Adequate nutrition, fetal monitoring and protection from disease
- Avoidance of teratogenic substances like exposure to radiation and consumption of alcohol and drugs

b. Analysis of fetus

- By amniocentesis, fetoscopy, fetal biopsy and ultrasound

At delivery

- Delivery conducted by expert doctors and staff, especially in the cases of high-risk pregnancy (e.g. maternal conditions of diabetes, hypertension etc.)
- Apgar scoring done at 1 and 5 minutes after the birth of the child
- Close monitoring of mother and child
- Injection of gamma globulin, which can prevent Rh-negative mothers from developing antibodies that might otherwise affect subsequent children.

Childhood

- Proper nutrition throughout the developmental period and particularly during the first 6 months after birth.

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...pecific metabolic disorders until no

- Avoidance of hazards in the childôs environment to avert brain damage from causes such as lead poisoning, ingestion of chemicals or accidents.

Secondary Prevention

- Early detection and treatment of preventable disorders. For example, phenylketonuria and hypothyroidism can be effectively treated at an early stage by dietary control or hormone replacement therapy.

- Early recognition of presence of mental retardation. A delay in diagnosis may cause unfortunate delay in rehabilitation.

- Psychiatric treatment for emotional and behavioural difficulties.

Tertiary Prevention

This includes rehabilitation in vocational, physical and social areas according to the level of handicap. Rehabilitation is aimed at reducing disability and providing optimal functioning in a child with mental retardation.

Care and Rehabilitation of the Mentally Retarded

The main elements in a comprehensive service for mentally retarded individuals and their families include:

- The prevention and early detection of mental handicaps.

- Regular assessment of the mentally retarded personôs attainments and disabilities.

- Advice, support and practical measures for families.

- Provision for education, training, occupation or work appropriate for each handicapped person.

- Housing and social support to enable self-care.

- Medical, nursing and other services for those who require them as outpatients, day patients or inpatients.

- Psychiatric and psychological services.

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The general approach to care is educational and psychosocial. The family doctor and pediatrician are mainly responsible for the early detection and assessment of mental retardation. The team providing continuing healthcare also includes psychologists, speech therapists, nurses, occupational therapists and physio-therapists.

The mildly retarded

A few mildly retarded children require fostering, boarding school placements or residential care, but usually specialist services are not required. Mildly retarded adults may need help with housing, employment or with the special problems of old age.

The severely retarded

In case of children, some require special services throughout their lives, which may include a sitting service, day respite during school holidays, or overnight stays in a foster family or residential care. In case of adults, provisions are required for work, occupation, housing, adult education, etc. The main principle now guiding the provision of resources is that the retarded person should be given sufficient help to be able to use the usual community services, rather than to provide specialist segregated services.

Education and training: The aim is that as many mentally retarded children as possible are educated in ordinary schools either in normal classes or in special classes. There is now an increasing use of more specialist teaches and a variety of innovative procedures for teaching language and other methods of communication. Before leaving school, these children require reassessment and vocational guidance.

Hints for successful skill training:

- Divide each training activity into small steps and demonstrate.
- Give the mentally retarded person repeated training in each activity.
- Give the training regularly and systematically: Do not let parents get impatient.
- Start the training with what the child already knows and then proceed to the skills that need to be trained. By this the child will have a feeling of success and achievement.

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...f the child attains near success, by ...ing that he likes.

- Reduce the reward gradually as he masters a skill and takes up another skill for training.

- Use the training materials which are appropriate, attractive and locally made.

- Remember, children learn better from children of the same age. Therefore, try and involve normal children of the same age in training the mentally retarded child, after orienting the normal child appropriately.

- Remember, there is no age limit for training a mentally retarded person.

- Assess the child periodically, preferably once in four or six months.

- Remember, a mentally retarded child learns very slowly. Tell the parents not to be dejected at the slow process, nor feel threatened by the childôs failure.

Vocational training

The activities included in vocational training are work preparation, selective placement, post placement and follow up.

For example, MITRA Special School and Vocational Training Centre for the Mentally Retarded.

Help for families: Help for families is needed from the time that the diagnosis is first made; adequate time must be allowed to explain the prognosis; indicate what help can be provided and discuss the part that the parents can play in helping their child to achieve full potential.
When the child starts school, the parents should not only be kept informed about his progress, but should feel involved in the planning and provision of care.

Families are likely to need extra help when the child is approaching puberty or leaving school; both day and overnight cares are often required to relieve caregivers and to encourage the retarded person to become more independent.

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unselling

Stage 1: information regarding the condition of the mentally retarded child. Avoid giving misleading information or building false hopes in the parents.

Stage 2: Help the parents to develop right attitudes towards their mentally retarded child (to prevent overprotection, rejection, pushing the child too had). Handle guilt feelings in parents

Stage 3: Create awareness in the parents regarding their role in training the child. The parents should be made to realize that training a mentally retarded child does not need complex skills and with repeated training in simple steps, the child can learn.

Parents are taught behaviour modifications techniques to decrease or eliminate problematic behaviours, increase adaptive behaviours and develop new skills. Some of these techniques include positive reinforcement, shaping, prompting, modeling, extinction procedures etc. Parents should demonstrate how their training has helped their child to acquire new skills. This will give them a sense of achievement, thus making them more involved in the care.

Some questions parents ask

1. Is mental retardation same as mental illness?

   No. Mentally retarded persons are not mentally ill. The mentally retarded person are just slow in their development.

2. Is mental retardation curable?

   No. Mental retardation is a condition which cannot be cured. But timely and appropriate intervention can help the mentally retarded person to learn several skills.

3. Can marriage solve the problems of mental retardation?

   No. Many people think that after marriage, the mentally retarded person will become active and responsible, or sexual satisfaction will cure the person. That is not so. Marriage will only further complicate the problem. When it is known that a mentally retarded person cannot be totally independent, it will not be possible for him/her to look after his/her family.

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...ns become normal as they grow older?

...ôs mental development is slower than that of a normal person. Therefore, when their actual age increases with time, the mental development does not occur at the same pace to catch up with the actual age.

5. Is mental retardation an infectious disease?

No. Many people think that by allowing normal children to mix, eat or play with mentally retarded children, the normal children will also develop mental retardation. This is wrong. Interaction between mentally retarded children and normal children on the other hand, helps in the improvement of mentally retarded children.

6. Is it true that the mentally retarded persons cannot be taught anything?

No. Mentally retarded persons can be taught many things, but they need to be trained systematically. They can perform many jobs under supervision.

7. Is it true that mental retardation is due to karma and hence nothing can be done about it?

No. Believing that mental retardation is due to their karma helps the parents to be free from the feelings of guilt. Parents must be told that whatever may be the cause, training the child will improve the condition. The earlier the training, the better the chances of improvement.

Residential Care: Parents should be supported in caring for their retarded children at home, or if they work is too heavy a burden for them, the child should be cared for in day care centres, halfway homes etc.

Specialist medical services: Retarded children and adults often have physical handicaps or epilepsy for which continuing medical care is needed.

Psychiatric services: Expert psychiatric care is an essential part of a comprehensive community service for the mentally retarded.

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Assessment

- Assessment of early infant behaviours to indicate a cognitive disability among high-risk children should be closely observed (e.g. children born to elderly primips, birth trauma etc.); early infant behaviours that may indicate a cognitive disability include non-responsiveness to contact, poor eye contact during feeding, slow feeding, diminished spontaneous activity, decreased responsiveness to surroundings, decreased alertness to voice or movement and irritability.

- Documentation of daily living skills.

- A careful family assessment for information on:

  - the familyôs response to the child

  - presence of other members with impaired cognition in the family

  - degree of independence encouraged at home

  - stability of the family unit

- Psychological assessment: This is directed at the interaction between the individual and people who are closely involved in care and determining the correct needs and wishes for the future. It should examine opportunities for learning new skills, making relationships, and achieving maximum choice about the way of life.

Intervention

- The long-term goals for these children are highly individualized and are dependent on the level of mental retardation. Parents should be involved in establishing realistic goals for their mentally retarded child. Some of these goals can be:

  - the child dresses himself

  - the child maintains continence of stool and urine

  - the child demonstrates acceptable social behaviours

  - the adolescent participates in a structured work program

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...ms are essential to maximize the ...elopment. This necessitates early recognition and referral. Nurses have an opportunity to evaluate children in the nursery, in the clinic during well-child healthcare, in schools and during acute management. The potential of each child will vary according to the degree of mental retardation. The key for success is that the childôs strengths and potential abilities are emphasized rather than deficits.

- The nurse can participates in programs that teach infant stimulation, activities of daily living and independent self-care skills. A successful technique in the treatment of the mentally retarded is operant conditioning. It focuses on changing or modifying the individualôs response to the environment by reinforcing certain desirable patterns of behaviour or eliminating undesirable patterns.

- In addition, learning social skills and adaptive behaviours assist the child in building a positive self-image. For older children and adolescents assistance is needed to prepare them for a productive work life.

- Sexuality becomes a major concern, as these children may form emotional attachment to those of the opposite sex and have normal sexual desires. However, their decision making skills are limited.

- In all instances, it is important for the nurse to maintain a non-threatening approach. Very often these children do not understand why physical assessment, therapeutic approaches and evaluative measures are needed. Proper explanation and relevant information should be given to the parents and their help should be enlisted in bringing out the best out of the child. Close collaboration with all members of the team involved in the care of the child is highly essential for a successful outcome. To a large extent the nurse is responsible for the emotional climate of the setting in which she is employed

3.4 Disorders of Psychological Development

Specific developmental disorders of speech and language

These are disorders in which normal patterns of language acquisition are disturbed from the early stages of development. The conditions are not directly attributable to neurological or speech mechanism abnormality or mental retardation.

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lopmental language disorder or dysphasia, ulation disorder or phonological disorder or dyslalia, disorder, receptive language disorder and other developmental disorders of speech and language.

Specific developmental disorders of scholastic skills

Specific developmental disorders of scholastic skills are divided further into specific reading disorder, specific spelling disorder and specific arithmetic disorder.

Specific reading disorders (dyslexia) should be clearly distinguished from general backwardness in scholastic achievement resulting from low intelligence or inadequate education. It is characterized by a slow acquisition of reading skills, slow reading speed, impaired comprehension, word omissions and distortions and letter reversals.

The main feature of the *specific spelling disorder* is significant impairment in the development of spelling skills in the absence of a history of specific reading disorder. The ability to spell orally and to write out words correctly are both affected.

Specific arithmetic disorder involves deficit in basic computational skills of addition, subtraction, multiplication and division.

Specific development disorders of motor function

Children with this disorder have delayed motor development, which is below the expected level on the basis of their age and general intelligence. The main feature of this disorder is a serious impairment in the development of motor coordination, which results in clumsiness in school work or play.

Pervasive developmental disorders

The term Pervasive Developmental Disorders (PDD) refers to a group of disorder characterized by abnormalities in communication and social interaction and by restricted repetitive activities and interests. These abnormalities occur in a wide range of situations, usually development is abnormal from infancy and most cases are manifest before the age of 5 years. PDD includes childhood autism, a typical autism, Rettôs Syndrome, Aspergerôs syndrome, childhood disintegrative disorder and other pervasive developmental disorders.

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Prevalence is 4-5/10,000 in children under 16 years of age. Male to female ratio is 4 or 5 to 1. The disorder is evenly distributed across all socio-economic classes.

Childhood autism

In 1908, Heller from Australia reported 6 cases of a disintegrative psychoses with onset in the 3rd or 4th year of life in children whose development was normal. Kenner (1943) identified a relatively homogenous group of children with onset of psychoses in the 1st and 2nd year of life whom he designated early ñinfantile autismò and ñautistic disturbances of affect contactò. Lauretta Bender first used the term ñchildhood schizophreniaò to characterize psychotic children. Now all these terms have been replaced and the condition is currently known as Childhood Autism in ICD10, or Autistic Disorder in DSMIV.

Etiology

Genetic factors The higher concordance rate in monozygotic than dizygotic twins (36% vs 0%) suggests a genetic factor. Siblings of autistic children show a prevalence of autistic disorder of 2 percent (50 times over expected prevalence).

Biochemical factors At least 1/3rd of patients with autistic disorder have elevated plasma serotonin.

Medical factors There is an elevated incidence of early development problems such as post-natal neurological infections (meningitis, encephalitis), congenital rubella and cytomegalovirus, phenylketonuria and rarely perinatal asphyxia. The other inborn errors of metabolism associated with autism are tuberous sclerosis and neurofibromatosis. About 2 to 5 percent appears to have Fragile X chromosome syndrome. Neurological abnormalities are present in about one-quarter of cases.

Perinatal factors During gestation maternal bleeding after the first trimester and meconium in the amniotic fluid have been reported in the histories of autistic children. There is also a high incidence of medication usage during pregnancy in the mothers of autistic children.

Psychodynamic and parenting influences and social environment Some of the specific causative factors proposed in these theories are parental rejection, child responses to deviant parental personality characteristics, family break up, family stress, insufficient stimulation and faulty communication patterns (Schreibman and Charlop, 1989).

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s studies, describe the parents of autistic children as
ss individuals, involved in career and intellectual
pursuits, who were aloof, obsessive and emotionally cold. The term órefrigerator parentsô was coined to describe their lack of warmth and affectionate behaviour. Mahler and associates (1975) suggested that the autistic child is fixed in the presymbiotic phase of development. In this phase, the child creates a barrier between self and others. The normal symbiotic relationship between mother and child followed by the progression to separation/individualization does not occur. Ego development is inhibited and the child fails to achieve a sense of self.

Theory-of-mind in autism Theory-of-mind describes the developmental process whereby the child comes to understand othersô mind, or to anticipate what others may be thinking, feeling or intending. Children with autistic disorder are sometimes said to be ómind-blindô, in that they lack the ability to put themselves in the place of another person.

Electrophysiological changes Brain stem auditory evoked responses (BASRS) of autistic children showed impairment in sensory modulation at brain stem level.

Neuroanatomical studies These studies have shown an enlargement of lateral ventricles and cerebellar degeneration.

Behavioural characteristics

- Autistic aloofness (unresponsiveness to parentôs affectionate behaviour, by smiling or cuddling)
- Gaze avoidance or lack of eye-to-eye contact
- Dislikes being touched or kissed
- No separation anxiety on being left in an unfamiliar environment with strangers
- No or abnormal social play. Failure to play with peers and unable to make friends
- Failure to develop empathy
- Marked lack of awareness of the existence or feelings of others
- Anger or fear without apparent reason and absence of fear in the presence of danger.

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- Gross deficits and deviances in language development.

- No mode of communication such as babbling, facial expression, gestures, mime etc.

- Absence of imaginative activity such as play acting of adult roles, fantasy characters of animals, lack of interest in imaginative stories.

- Marked abnormality in the production of speech (volume, pitch, stress, rhythm, rate etc).

- Marked abnormalities in the form or content of speech including stereotyped or repetitive use of speech, use of óyouô when ódô is meant, idiosyncratic use of phrases.

- Marked impairment in the ability to initiate or sustain a conversation with others despite adequate speech.

Activities

- Marked restricted, repertoire of activities and interests.

- Stereotyped body movements e.g. hand flicking or twisting, spinning, head banging etc.

- Persistent preoccupation with parts of objects (e.g. spinning wheels of toy cars) or attachment to unusual objects.

- Marked distress over changes in trivial aspects of environment.

- Markedly restricted range of interests and a preoccupation with one narrow interest.

Other features

- Autistic children are resistant to transition and change.

- Over-responsive or under-responsive to sensory stimuli.

- May have a heightened pain threshold or an altered response to pain.

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ural problems like hyperkinesis, aggression, temper lf-injurious behaviour, head banging, biting, d hair pulling are common.

- Idiot Savant Syndrome: In spite of a pervasive or abnormal development of functions, certain functions may remain normal, e.g. calculating ability, prodigious remote memory, musical abilities, etc.

- Absence of hallucinations, delusions, loosening of associations as in schizophrenia.

- Kannerôs ñAutistic triadò. Kanner said autistic aloofness, speech and language disorder and obsessive desire for sameness constitute a triad characteristic of infantile autism.

Course and prognosis

- Autistic disorder has a long course and guarded prognosis.

- About 10 to 20 percent autistic children begin to improve between 4 to 6 years of age and eventually attend an ordinary school and obtain work.

- 10 to 20 percent can live at home, but need to attend a special school or training center and cannot work.

- Sixty percent improve little and are unable to lead an independent life, mostly needing long-term residential care.

- Those who improve may continue to show language problem, emotional coldness and odd behaviour.

Treatment

- Pharmacotherapy is a valuable treatment for associated symptoms like aggression, temper tantrums, self-injurious behaviour, hyperactivity and stereotypies. Some drugs that have been used are risperidone, serotinin specific reuptake inhibitors, clomipramine and lithium. Antiepileptic medication is used for generalized seizures.

- Behavioural methods: Contingency management may control some of the abnormal behaviour of autistic children. The term contingency management refers to a group of procedures based

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...any behaviour persists, some of its ...ng it. If these consequences can be ... change. The parents instructed and supervised by a clinical psychologist often carry out this method at home.

Contingency management has the following stages:

- First the behaviour to be changed is defined and another person (usually a nurse, spouse or parent) is trained to record it; for example, a mother might count the number of times a child with learning difficulties shouts loudly.

- Second, the events that immediately follow (and therefore are presumed to reinforce the behaviour) are identified; for example, the parents may pay attention to the child when he shouts but ignore him at other times.

- Third, reinforcements are devised for alternative behaviours, for example, being approved or earning points by refraining from shouting for an agreed time. Staff or relatives are trained to provide the chosen reinforcements immediately after the desired behaviour and to withhold them at other times.

- As treatment progresses, records are kept of the frequency of the problem behaviours and of the desired behaviours.

- Although treatment is mainly concerned with the consequences of behaviour, attention is also given to changing any events that might be provoking the behaviour. For example, in a psychiatric ward, the abnormal behaviour of one child may be provoked on each occasion by the actions of another child.

- Special schooling: Most autistic children require special schooling and older adolescents many need vocational training.

- Counseling and supportive therapy: The family of an autistic child needs considerable help to cope with the childôs behaviour which is often distressing.

- Others: Development of a regular routine, positive reinforcements to teach self-care skills, speech therapy or sign language teaching, behaviour techniques to encourage interpersonal interactions.

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ent Assessment

The following factors need to be considered in assessing an autistic child (Lord and Rutter, 1994):

- Cognitive level
- Language ability
- Communication skills, social skills and play and repetitive are other abnormal behavior
- Stage of social development in relation to age, mental age and stage of language development
- Associated medical conditions
- Psychosocial factors.

Intervention

- Work with the child on a one-to-one basis.
- Protect the child when self-mutilative behaviour occurs. Devices such as helmet, padded mittens, or arm covers may be used.
- Try to determine if self-mutilative behaviour occurs in response to increasing anxiety, and if so, to what the anxiety may be attributed. Intervene with diversion or replacement activities as anxiety level starts to rise. These activities may provide needed feelings of security and substitute for self-mutilative behaviour.
- Assign limited number of caregivers to the child. Ensure warmth, acceptance and availability are conveyed.
- Provide child with familiar objects such as familiar toys of a blanket. Support childôs attempts to interact with others.
- Give positive reinforcement for eye contact with something acceptable to the child (e.g. food, familiar object). Gradually replace with social reinforcement (i.e. touch, hugging).
- Anticipate and fulfill the childôs needs until communication can be established.

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...o express his needs verbally. Seek

- Give positive reinforcement when eye contact is used to convey nonverbal expressions or when the child tries to speak.

- Teach simple self-care skills by using behaviour modification techniques.

- Language training plays a big part in teaching autistic children. At first they have to learn the names of things by linking the name with the actual object. When teaching the word ótableô they must see and feel a real table and lots of different tables, otherwise they may think that table refers to only that particular object. Look at childôs face and pronounce simple words. Ask the child to repeat the words. Show picture books and name the objects. Verbs like sitting, walking, running can be acted to show the child what these words mean.

- Autistic children have personal identity disturbance and need to be assisted to recognize separateness during self-care activities, such as dressing and feeding. The child should be helped to name own body parts. This can be facilitated with the use of mirrors, drawings and pictures of himself. Encourage appropriate touching of and being touched by others.

- The role of the parent is crucial for any intervention with the autistic child; the parent generally acts as a co-therapist and plays an integral role in treatment. The behaviour of their autistic child is often very distressing and parental counseling begins with clarification of the diagnosis and an explanation of the characteristics of the disorder. To effectively participate in the treatment program, the parents must have acknowledged the extent of their childôs handicap and be able to work with him at the appropriate developmental level.

A typical Autism

A pervasive developmental disorder that differs from autism in terms of either age of onset or failure to fulfill diagnostic criteria i.e. disturbance in reciprocal social interactions, communication and restrictive stereotyped behaviour. Atypical autism is seen in profoundly retarded individuals.

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own cause, reported only in girls. It is characterized by apparently normal or near-normal early development which is followed by partial or complete loss of acquired hand skills and of speech, together with deceleration in head growth, usually with an onset between 7 and 24 months of age.

Asperger's Syndrome

The condition is characterized by severe and sustained abnormalities of social behaviour similar to those of childhood autism with stereotyped and repetitive activities and motor mannerisms such as hand and finger twisting or whole body movements. It differs from autism in that there is no general delay or retardation of cognitive development or language.

4.0 CONCLUSION

This unit looked at classification of childhood psychiatric mental disorder and disorders of psychological development in childhood.

5.0 SUMMARY

The understanding of learners in this new field of psychiatry will enhance their better management of childhood psychiatric disorders.

6.0 TUTOR-MARKED ASSIGNMENT

1. List the disorders of psychological development
2. Explain two of the disorders of psychological development.

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CHILDHOOD PSYCHIATRY II

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1.0 INTRODUCTION

This unit is a continuation of the last unit on disorders of childhood psychiatry. The focus of this unit is behavioural and emotional disorders with onset usually occurring in childhood and adolescence such as hyperkinetic disorder, conduct disorder, emotional disorders with onset specific to childhood, disorders of social functioning.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- identify various behavioural and emotional disorders with onset in childhood and adolescence
- explain five of the behavioural and emotional disorders.

3.0 MAIN CONTENT

3.1 Behavioural and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence

Hyperkinetic disorder

Hyperkinetic disorder (Attention-Deficit Hyperactivity Disorder or ADHD in DSMIV) is a persistent pattern of inattention and or hyperactivity more frequent and severe that is typical of children at a similar level of development. The syndrome was first described by Heinrich Hoff in 1854.

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A prevalence of 1.7 percent was found among primary school children (Taylor et al, 1991). ADHD is four times more common in boys than in girls.

Etiology

Biological influences

Genetic factors

- There is greater concordance in monozygotic than in dizygotic twins.
- Siblings of hyperactive children have about twice the risk of having the disorder as does the general population.
- Biological parents of children with the disorder have a higher incidence of ADHD than do adoptive parents.

Biochemical theory

A deficit of dopamine and norepinephrine has been attributed in the overactivity seen in ADHD. This deficit of neurotransmitters is believed to lower the threshold for stimuli input.

Pre, peri and postnatal factors

- Prenatal toxic exposure, prenatal mechanical insult to the fetal nervous system.
- Prematurity, fetal distress, precipitated or prolonged labour, perinatal asphyxia and low Apgar scores.
- Postnatal infections, CNS abnormalities resulting from trauma etc.

Environmental influences

- Environmental lead.
- Food additives, colouring preservatives and sugar have also been suggested as possible causes of hyperactive behaviour but there is no definite evidence.

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- Prolonged emotional deprivation
- Stressful psychic events
- Disruption of family equilibrium.

Clinical features

- Sensitive to stimuli, easily upset by noise, light, temperature and other environmental changes.
- At times the reverse occurs and the children are flaccid and limp, sleep more and the growth and development is slow in the first month of life.
- More commonly active in crib, sleep little.
- General coordination deficit.
- Short attention span, easily distractable.
- Failure to finish tasks.
- Impulsivity.
- Memory and thinking deficits.
- Specific learning disabilities.

In school

- Often fidgets with hands or feet or squirms in seat.
- Answers only the first two questions; often blurts out answers to questions before they have been completed.
- Unable to wait to be called on in school and may respond before everyone else.
- Has difficulty awaiting turn in games or group situations.
- Often loses things necessary for tasks or activities at school.

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- Explosive or irritable.
- Emotionally labile and easily set off to laughter or tears.
- Mood is unpredictable.
- Impulsiveness and an inability to delay gratification.
- Often talks excessively.
- Often engages in physical dangerous activities without considering possible consequences (for example, runs into street without looking).

Diagnosis

- Detailed prenatal history and early developmental history.
- Direct observation, teacherôs school report (often the most reliable), parentôs report.

Treatment

Pharmacotherapy

- CNS stimulants: Dextroamphetamine, methylphenidate, pemoline
- Tricyclic antidepressants
- Antipsychotics
- Serotonin specific re-uptake inhibitions
- Clonidine.

Psychological Therapies

- Behaviour modification techniques
- Cognitive behaviour therapy
- Social skills training

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- Develop a trusting relationship with the child. Convey acceptance of the child separate from the unacceptable behaviour.

- Ensure that patient has a safe environment. Remove objects from immediate area in which patient could injure self due to random hyperactive movements. Identify deliberate behaviours that put the child at risk for injury. Institute consequences for repetition of this behaviour. Provide supervision for potentially dangerous situations.

- Since there is non-compliance with task expectations, provide an environment that is as free of distractions as possible.

- Ensure the childôs attention by calling his name and establishing eye contacts, before giving instruction.

- Ask the patient to repeat instructions before beginning a task.

- Establish goals that allow patient to complete a part of the task, rewarding each step completion with a break for physical activity.

- Provide assistance on a one-to-one basis, beginning with simple concrete instructions.

- Gradually decrease the amount of assistance given to task performance, while assuring the patient that assistance is still available if deemed necessary.

- Offer recognition of successful attempts and positive reinforcement for attempts made. Give immediate positive feedback for acceptable behaviour.

- Provide quiet environment, self-contained classrooms and small group activities. Avoid over stimulating places such as cinema halls, bus stops and other crowded persons.

- Assess parenting skill level, considering intellectual, emotional and physical strengths and limitations. Be sensitive to their needs as there is often exhaustion of parental resources due to prolonged coping with a disruptive child.

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mation and materials related to the childôs disorder parenting techniques. Give instructional materials in written and verbal form with step-by-step explanations.

- Explain and demonstrate positive parenting techniques to parents or caregivers, such as time-in for good behaviour, or being vigilant in identifying the childôs behaviour and responding positively to that behaviour.

- Educate child and family on the use of psychostimulants and behavioural response anticipated.

- Coordinate overall treatment plan with schools, collateral personnel, the child and the family.

Conduct Disorders

Conduct disorders are characterized by a persistent and significant pattern of behaviour in which the basic rights of others are violated or rules of society are not followed. The diagnosis is only made when the conduct is far in excess of the routine mischief of children and adolescents. The onset occurs much before 18 years of age, usually even before puberty. The disorder is much more (about 5 to 10 times) common in boys.

Etiology

Genetic factors: Studies with monozygotic and dizygotic twins as well as with non-twin siblings have revealed a significantly higher number of conduct disorders among those whose family members are affected with the disorder (Baum, 1989). Alcoholism and personality disorder in the father is reported to be strongly associated with conduct disorders.
Biochemical factors: Various studies have reported a possible correlation between elevated plasma levels of testosterone and aggressive behaviours.

Organic factors: Children with brain damage and epilepsy are more prone to conduct disorders.

Psychosocial Factors

- Parental rejection.

- Inconsistent management with harsh discipline.

- Frequent shifting of parental figures.

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- Absent father.
- Parents with antisocial personality disorder or alcohol dependence.
- Parental permissiveness.
- Marital conflict and divorce in parents.
- Associations with delinquent subgroups.
- Inadequate/inappropriate communication patterns in the family.

Clinical Features

- Frequent lying.
- Stealing or robbery.
- Running away from school or home.
- Deliberate fire-setting.
- Breaking someone elseôs house articles, car etc.
- Deliberately destroying otherôs properties.
- Cruelty towards other people and animals.
- Physical violence with rape, assaultive behaviour and use of weapons etc.
- In addition to the typical symptoms of conduct behaviour, secondary complications often develop like, drug abuse and dependence, unwanted pregnancies, syphilis, AIDS, criminal record, suicidal and homicidal behaviour.

Treatment

The treatment is difficult. The most common mode of management is placement in a corrective institution. Behavioural, educational and psychotherapeutic measures are employed for changing the behaviour.

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ay be indicated in the presence of epilepsy yperactivity (stimulant medication), impulse control ic aggressive behaviour (lithium, carbamazepine) and psychotic symptoms (antipsychotics).

Nursing Intervention

- The nurse should bear in mind that there is always the risk of violence in these children. She should therefore observe the childôs behaviour frequently during routine activities and interactions. She should be aware of behaviour that indicates a rise in agitation.

- Redirect violent behaviour with physical outlets for suppression of anger and frustration.

- Ensure that a sufficient number of staff is available to indicate a show of strength if necessary. Administer tranquilizing medication as prescribed. Use of mechanical restraints or isolation should be used only if the situation cannot be controlled by less restrictive means.

- Explain to the client the correlation between feelings of inadequacy and the need for acceptance from others, and how these feelings provoke aggression or defensive behaviour such as blaming others for own faulty behaviour. Practice more appropriate responses through role play.

- Set limits on manipulative behaviour and identify the consequences of manipulative behaviour. Administer the consequences matter-of-factly and in a non-threatening manner if such behaviours occur.

- Provide immediate positive feedback for acceptable behaviour.

- Encourage the child to maintain a log book and make daily entries of his behaviour. The entry should consist of a brief statement of an incident when the client was angry or disagreed with another person, what the client thought about the incident afterwards (in his own words), what the client thought about doing, and what he actually did, and the outcome. This provides opportunity for the child to identify his predominant patterns of thinking and behaving in different situations, and recognize new and acceptable ways of responding in situations which provoke such behaviours.

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ent before discharge. Provide feedback vioural responses and areas where continued work is needed. Encourage client to continue the log after discharge.

- Social skills training: Some views of aggression emphasize the aggressive childôs limited repertoire of cognitive and behavioural skills related to successful peer and adult interaction. This perspective has led to the use of social skills training in the programmes of conducive disorder. The key steps for teaching social skills are:

  - presenting the target skill to the child by describing it and discussing when it is relevant;
  - demonstrating the skill by modeling;
  - asking the child to rehearse the skill and providing feedback;
  - role playing example situations that call for use of the skill; and
  - giving the child an assignment involving practice of the skill in real life situations outside the clinical setting.

- Working with the school: Aggressive children often display problems across settings, including school, or even in a particular classroom. The nurse should emphasize on close collaboration between parents and school personnel likely to come into contact with the child (principal, assistant principal, guidance counselors, school psychologists etc.). Children who see their parents and teachers working together find it easier to control their behaviour in home and in school. Truancy requires separate consideration.

Pressure should be brought upon the child to return to school, and if possible, the support of the family should be enlisted. At the same time an attempt should be made to resolve educational or other problems at school. In all this, it is essential to maintain good communication between the nurse, parents and teachers.

Juvenile Delinquency

According to Dr. Sethna, Juvenile delinquency involves wrongdoing by a child or a young person who is under an age specified by the law of the place concerned. From the legal point of view, a juvenile delinquent is a person who is below 16 years of age (18 years, in case of a girl) who indulges in antisocial activity.

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a clarification made by the Supreme Court in the tice Act, that a regular court would try a juvenile if crossing the age of 16 though he might have committed the crime when he was under the age of 16 (The Hindu, 15th May 2000).

Causes

Social causes

- Defects of the family, like broken families, uncaring attitude of parents, bad conduct of parent, etc.
- Defects of the school, like harsh punishment by the teachers, weakness in some subjects, a level of education that is above the childôs capacity.
- Children living in crime-dominated areas.
- Absent or defective recreation.
- War and post-war conditions.

Psychological causes: Personality characteristics, (emotional instability, immaturity), emotional insecurity and mental illness.

Economic causes: Poverty, leading to stealing, prostitution and other antisocial activities to satisfy unfulfilled desires.

Reformatory Measures

- Probation, where the juvenile delinquent is kept under the supervision of a probation officer, whose job is to help him get established in normal life.
- Institutions like reformatory schools, remand homes, certified schools, auxiliary homes. These institutions provide for all-round progress of the delinquent.
- Psychological therapies like play therapy, finger-painting, psychodrama.
- Governmental measures: The Childrenôs Act of 1977 under which remand homes and borstal schools were made available; vocational training and follow-up services. Under the Care

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Central Government, 5 borstal schools, ion hostels have been established.

Separation Anxiety Disorder

In these disorders there is excessive anxiety concerning separation from those individuals to whom the child is attached such as mother, fathers, caregiver, etc.

Clinical Features

- An unrealistic worry about possible harm befalling major attachment figures or fear that they will leave and not return.
- Persistent reluctance or refusal to go to sleep, without being near or next to a major attachment figure.
- Persistent inappropriate fear of being alone.
- Repeated nightmares.
- Repeated occurrence of physical symptoms e.g. nausea, stomachache, headache etc., on occasions that involve separation from a major attachment figure, such as leaving home to go to school.
- Excessive tantrums, crying and apathy immediately following separation from a major attachment figure.

Treatment

Individual counseling: This is often useful to give the child opportunity to understand the basis for anxiety and also to teach the child some strategies for anxiety management.

Parental counseling: Parental counseling is needed when there is evidence that they are overanxious or over-protective about the child. They should be persuaded to allow the child more autonomy.

Family therapy: It is often needed when the childôs disorder appears to be related to the family system. Treatment is designed to promote healthy functioning of the family system.

Pharmacological management: Anxiolytic drugs such as diazepam may be needed occasionally when anxiety is extremely severe, but they should be used for short periods only.

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order

oms are common in childhood and usually concern animals, insects, darkness, school and death. The prevalence of more severe phobias varies with age. In most cases, all fears decline by early teenage years.

Treatment

Most childhood phobias improve without specific treatment, provided the parents adopt a firm and reassuring approach. For phobias that do not improve, behavioural treatment combined with reassurance and supports are most helpful. Systematic desensitization (gradual introduction of the phobic object or situation while the subject is in a state of relaxation), is an established treatment. Other methods are implosive theraphy or flooding which involves persuading the child to remain in the feared situation at maximum intensity from the start, (the reverse of desensitization).

Social Anxiety Disorder

Children with this disorder show a persistent or recurrent fear and avoidance of strangers which interferes with social functioning. Treatment includes simple behavioural methods, combined with reassurance and support.

Sibling Rivalry Disorder

Sibling rivalry/jealousy may be shown by marked competition with siblings for the attention and affection of parents, associated with unusual pattern of negative feelings. Onset is during the months following the birth of the younger sibling. In extreme cases there is over-hostility, physical trauma towards and undermining of the sibling, regression with loss of previously acquired skills (such as bowel and bladder control) and a tendency to babyish behaviour. There is an increase in oppositional behaviour with the parents, temper tantrums and dysphoria exhibited in the form of anxiety, misery or social withdrawal.

Management

- Parents should be helped to divide their attention appropriately between the two children.
- Help the older child feel valued. At the same time, limits should be set as appropriate.

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...ch as preparing the child mentally for ...luring pregnancy itself and involving ...g.

Elective Mutism

This condition is characterized by a marked, emotionally determined selectively in speaking such that the child demonstrates his language competence in some situations, but fails to speak in other situations. Most typically the child speaks at home or with close friends and is mute at school or with strangers.

Management

Management includes a combination of behavioural and family therapy techniques to promote communication and the use of speech. Individual psychotherapy may also help.

Tic Disorders

Tic is an abnormal involuntary movement, which occurs suddenly, repetitively, rapidly and is purposeless in nature. It is of two types:

1. Motor tic, characterized by repetitive motor movements.

2. Vocal tips, characterized by repetitive vocalizations.

Tic disorders can be either transient or chronic. A special type of chronic tic disorder is Gilles de la Touretteôs syndrome or Touretteôs disorder. This is characterized by multiple motor and vocal tics, with duration of more than 1 year. Onset is usually before 11 years of age and almost always before 21 years of age. The disorder is more common (about 3 times) in males and has a prevalence rate of about 0.5 per 1000.

Types of the disorder

Motor Tics

Motor tics can be simple or complex.

Simple Motor Tics

These may include eye blinking, grimacing, shrugging of shoulders, tongue protrusion.

Complex Motor Tics

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stures, stamping, jumping, hitting self, squatting, s (repetition of observed acts), and copropraxia (obscene acts). Motor tics are often the earliest to appear; beginning in the head region and progressing downwards. These are followed by vocal tics.

Vocal Tics

Vocal tics also can be simple or complex.

Simple Vocal Tics: Simple vocal tics include coughing, barking, throat clearing, sniffing and clicking.

Complex Vocal Tics

These include echolalia (repetition of heard phrases), palilalia (repetition of heard words) coprolalia (use of obscene words), and mental coprolalia (thinking of obscene words).

Etiology of Tourette's syndrome: The etiology of Tourette's syndrome is not known but the presence of learning difficulties, neurological soft signs, hyperactivity, abnormal EEG record, abnormal evoked potentials and abnormal C.T. brain findings in some patients points towards a biological basis. There is some evidence to suggest that Tourette's syndrome may be inherited as autosomal dominant disorder with variable penetrance.

Treatment: Pharmacotherapy is the preferred mode of treatment. The drug of choice is haloperidol. In resistant cases or in case of severe side effects, pimozide of clonidine can be used. Behaviour therapy may be used sometimes, as an adjunct.

Non-organic enureses

It is a disorder characterized by involuntary voiding of urine by day and/or night which is abnormal in relation to the individuals mental age and which is not a consequence of a lack of bladder control due to any neurological disorder, epileptic attacks or any structural abnormality of urinary tract. Enuresis would not ordinarily be diagnosed in a child under the age of 5 years or with a mental age less than 4 years.

In most cases, enuresis is primary (the child has never attained bladder control). Sometimes it may be secondary (enuresis starting after the child achieved continence for a certain period of time).

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- Exclude any physical basis for enuresis by history, examination and if necessary, investigation of the renal tract.

- Explain to the parents and child about the maturational basis of the problem and the likelihood of spontaneous improvement.

- The child should be encouraged to keep a diary of the pattern of night time dryness/wetness, which can be done with a star chart. This consists of a record of dry nights with a star placed on the sheet for each dry night. The star chart system has 3 functions:

  - it provides an accurate record of the problem;

  - it tests motivation and cooperation of the child and the family; and

  - it acts as a positive reinforcement for the desired behaviour.

- Fluid restriction after 6 Oôclock in the evening.

- Interruption of childôs sleep and emptying the bladder in the toilet.

- **Bell and pad technique:** It is based on the classical conditioning behaviour. A bell is attached to the napkin or panties and when the child passes urine, the alarm goes off, the child then has to wake up, change his napkin, bed sheets, etc. Reinforcement is given for dry nights.

- **Medications:** Tricyclic antidepressants like imipramine or amitriptyline, 25-50mg at night. The mechanism of action is unknown, but results have demonstrated its effectiveness.

- The parents should be instructed not to blame the child in anyway. On no account should the child be embarrassed or humiliated, which will only serve to aggravate the problem.

Non-organic encopresis

It is the repeated voluntary or involuntary passage of feces, usually of normal or near normal consistency, in places not appropriate for that purpose in the individualôs socio-cultural setting.

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- Family tensions regarding the symptoms must be reduced and a non-punitive atmosphere must be created. Parental guidance and family therapy often is needed.

- Behavioural techniques e.g. star charts, in which the child places a star on a chart for dry or continent nights.

- Individual psychotherapy to gain the cooperation and trust of the child.

Feeding Disorder of Infancy and Childhood

It generally involves refusal of food and extreme faddiness in the presence of an adequate food supply and reasonably competent caregiver and the absence of organic disease. There may or may not be associated rumination (repeated regurgitation without nausea or gastrointestinal illness).

Pica

Pica of infancy and childhood is characterized by eating non-nutritive substances (soil, paint chipping, paper etc). Treatment consists of common-sense precautions to keep the child away from abnormal items of diet. Pica usually diminishes as the child grows older.

Stereotyped Movement Disorders

These disorders are characterized by voluntary, repetitive, stereotyped, nonfunctional, often rhythmic movements that do not form part of any recognized psychiatric or neurological condition. The movements include body rocking, head rocking, hair plucking, hair twisting, finger flicking, mannerisms and hand flapping.

Management

- Individual and family interventions.

- Behavioural strategies.

Stuttering (stammering)

It refers to frequent hesitation or pauses in speech characterized by frequent repetition or prolongation of sounds or syllables or words,

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eech. The usual treatment is speech

4.0 CONCLUSION

There are many behavioural and emotional disorders with onset usually occurring in childhood and adolescence in which proper knowledge of the mental health service providers will assist the individual patients, parents, family and the environment at large in either preventing or managing the cases.

5.0 SUMMARY

We do hope the learners have learnt greatly in this unit to help the clients/patients, parents, families and the society.

6.0 TUTOR-MARKED ASSIGNMENT

1. List five behavioural and emotional disorders with onset usually occurring in childhood and adolescence.
2. Describe the management in detail of any ONE.

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