Curriculum of the National Training Programme in

Mental Health NURSING

Phase II

Curriculum of the National Training Programme in Mental Health Nursing - Phase II

May 2018

The Asia Foundation

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Preface

The Asia Foundation's mental health and psychosocial support programme has been ongoing since its inception in 2005. A psychosocial approach to development work has been used through the programme to respond to the contextual changes in the country: transitioning from war to, post war, to development and reconciliation. In its work, the Foundation has found that psychosocial approaches to healing and improving well-being are effective in strengthening existing coping mechanisms that enable individuals, families, and communities to get on with their lives following a life threatening experience. Following the initial phases of the Victims of Trauma Treatment Programme (VTTP), the Foundation is currently implementing the VTTP-Modification. The VTTP-Modification aims to consolidate best practices in mental health and psychosocial support services (MHPSS) within the government and non-government sectors enabling them to lead and sustain the provision of care to victims of trauma, conflict, and other vulnerable communities. The Modification programme continues to strengthen the partnerships that were forged with the government and NGO sectors to develop the capacities and skills of government and NGO mental health cadres to provide effective service delivery. Nurses are a pivotal part of MHPSS service delivery, particularly nursing cadres, attached to acute psychiatry units and community psychiatry nurses. Relatedly, following the 'National Training Programme in Mental Health Nursing - Phase I" conducted in 2015-2016, a curriculum has been developed following an assessment study (2017) for the 'National Training Programme in Mental Health Nursing - Phase II". The three modules developed for the training are as follows:

Module 1 of the curriculum provides an introduction to Mental Health Nursing using the mode of History Taking and Mental Status Examination, the first module also has a session on psycho-pharmacology for nurses.

Module 2, focuses on basic counselling and communication skills, nursing management when working with aggression and parenting skills for building good child and adolescent mental health.

The subjects of nursing care in depression, rehabilitation and stress management and burnout prevention is the focus of Module 3 of the training curricula.

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List of Acronyms

5HT	Seretonin
ACH	Acetylcholine
CBT	Cognitive Behaviour Therapy
CNS	Central Nervous System
DA	Dopamine
ECT	Electro Convulsive Therapy
EPS	Extrapyramidal Side-effects
IM	Intramuscular
MAO	Monoamina Oxidase
MAOI	Monoamina Oxidase Inhibitors
MHPSS	Mental Health and Psycho Social Support
MoH	Ministry of Health
MSE	Mental State Examination
NE	Norepinephrine
NIMH	National Institute of Mental Health
PSR	Psychosocial Rehabilitation
REM	Rapid Eye Movement
SS	Serotonin Syndrome
SSRI	Serotonin Norepinephrine Reuptake Inhibitors
TAF	The Asia Foundation
TC	Technical Committee
ToT	Training of Trainers
USAID	United States Agency for International Development
WHO	World Health Organisation

Introduction

Nurses are a pivotal part of the mental health care team and one that is distributed widely throughout the island. In 2015, nursing cadres attached to the Acute Psychiatry Units were selected by the Mental Health Directorate of the Ministry of Health (MoH) to be trained in mental health and psychosocial support (MHPSS). A Technical Committee (TC) comprising of the Director Mental Health, Psychiatrists of the National Institute of Mental Health (NIMH), the Mental Health Focal Point of the World Health Organisation (WHO), the Director Nursing and The Asia Foundation (TAF) were formed to steer the development and implementation of the training programme.

With the objective of enhancing the knowledge, skills and attitudes on Mental Health and Psychosocial Support Services (MHPSS) of nurses and building a sustainable system within the MoH for ongoing training on MHPSS for nursing cadre though the development of a Training of Trainers (TOT), a total of 150 nurses island-wide were trained under the National Training Programme in Mental Health Nursing - Phase 1 in 2015-2016. It was noteworthy, that according to data collected from evaluation forms, of the 150 nurses trained, 110 nurses had not received any previous training in mental health, following graduation.

The process entailed a focus group discussion by the MoH in March 2015 to design an appropriate programme. A Training of Trainers (TOT) workshop for groups of 25 nurses was held in October 2015. A 10-day residential training programme for groups of 40 was implemented and 4 training programmes were conducted in the Sinhala medium while 1 training programme was conducted in Tamil. All the training programmes were facilitated by both doctors and nurses.

Varied teaching methodology was used – with a focus on interactive teaching methodology:

- Lectures
- Practicals
- Role Plays
- Supervision
- Small Group Discussions
- Problem Based Learning

Following the 2015-2016 National Training Programme, an assessment was carried out in 2017 to review the use and usefulness of the Phase I training, as well as to get an idea of the training needs of nurses attached to acute psychiatric units and community psychiatric nurses. Following the assessment and recommendations of the Technical Steering Committee, comprising a membership from The National Institute of Mental

Health (NIMH), Ministry of Health (MoH), World Health Organisation (WHO) and The Asia Foundation (TAF) a three-day refresher training for Nursing Officers in Acute Units and Community Psychiatric Units and Community Psychiatric nurses was designed to be carried out in 2018-2019. The programme will be implemented primarily by a nursing TOT group obtaining the support of Consultant Psychiatrists and Medical Officers as and when needed.

This curriculum, developed under the guidance of the Technical Steering Committee will be used as a training handbook for the National Training Programme in Mental Health Nursing- Phase II.

Module 1
A Brief Introduction to Mental Health Nursing

History Taking and Mental State Examination (MSE)

History taking and MSE are essential components of the assessment and evaluation of patients with mental illnesses. It is also a tool to assess risks in the field of mental health. Since nursing officers are the primary assessors in an acute or inward set up, they should possess skills to collect important details in the history of a patient and to do a reliable MSE. This helps to reach an accurate nursing diagnosis, plan good nursing care, reduce risks to patients as well as to the staff (by patients) and provide support with documents for legal purposes.

Objectives:

At the end of the training, the participants should:

1. Acquire knowledge and skills to collect a comprehensive psychiatric history and to do a reliable MSE,
2. Be able to do a risk assessment with the aid of the history and the MSE, formulate a nursing diagnosis and work out a nursing management plan.

Curriculum:

1. Understanding the key elements of psychiatric history taking and its importance,
2. Understanding what MSE is, its main components and their clinical implications,
3. Usage of correct terminology to explain the client's symptoms,
4. Perform a risk assessment and initiate appropriate nursing management,
5. Evening visit to the wards and perform history taking and mental state examinations followed by case discussions.

Psycho-pharmacology for Nurses

Psycho-pharmacology

Objectives:

At the end of the training, the participants should be able to:

1. Have a general idea about common psycho-tropic medications from a nursing perspective,
2. Identify and take remedial actions against the adverse effects of psycho tropic medications.

Curriculum:

1. Understanding what psycho-tropic medications are,
2. Knowing main classes of psycho-tropic medications,
3. Understanding the usages of different classes of psycho-tropics,
4. Knowing the common medications used in acute settings and in ward settings,
5. Knowing the common adverse effects of commonly used psycho-tropics in wards/ acute settings,
6. Understanding how to monitor effects of psycho-tropics,
7. Practical sessions simulating particular side effects of psycho-tropic medications: suggest remedial actions.

Study Material 1

Prasad's Story

Introduction

Prasad is a 24 year-old, single, unemployed person from Bandaragama (situated 20km from Colombo).

Source of Information

His history was obtained mainly from the patient and it was supported by collateral information from his parents.

Presenting Complaint

Prasad presented with a change of behaviour consisting of poor sleep, irritability and a conviction that he is being conspired against by his sister-in-law and neighbours for the past 2 months, along with violent behaviour against family members over a duration of several days.

History of the presenting complaint

Prasad had been well 2 months ago. He had been helping his elder brother in a small cultivation of green leaves (Kira Kotuwa) near his house. He recalled that two months ago, when he was traveling in a bus he had noticed that passengers were looking at him in a strange way. He had also noticed the bus stopping to take on a Buddhist monk, but the monk refused to get in, even though there were many vacant seats. Prasad had quickly got out of the bus at the next bus stop as he had felt that the bus and the passengers were up to no good and he had felt scared.

Prasad claims he had afterwards made inquiries about the bus and got to know that the bus belonged to a relative of one of his neighbours. He started paying more attention to this neighbour and after a while began to be convinced that he was being observed and spied upon by the neighbours. He soon realised that almost all the neighbours were colluding against him to do him harm. He had realised that the neighbours would know exactly when he would leave the house and would follow him, using different people and sometimes even children to spy on him.

Once when he had gone to the shop nearby, he noted that people were discussing him and making fun of him, because they kept laughing. He had asked them what they have been discussing and they lied to him saying that they had been talking about a local politician. He noticed that his brother's wife (his sister-in-law) was also behaving in a strange manner. He became suspicious of the sister-in-law and on one occasion had a fight with her about her coming into his room. He became convinced that she was the key figure among the persecutors and that it was she who was responsible for turning the neighbours and the family against him.
One week prior to admission, Prasad claims the reasons for his persecution became clear. It was raining heavily on that day and he heard something fall from the sky on to the roof of his room. He realised it was a gold sword that belonged to the God known

as ‘Ghana Deviyo’. He realised that he had been selected to receive the blessing of this deity and the neighbours on getting to know this had tried to harm him so that he would be prevented from receiving the deities blessing.

Prasad’s parents noticed that the patient was experiencing poor sleep over the last two months. He would stay up most of the night and listen to the radio or be seen pacing up and down in the garden. Usually a mild mannered person, Prasad had become an irritable person who frequently fought with his family, especially with his sister-in-law. Prasad had become more withdrawn and more preoccupied with his thoughts than before. He did not like to spend time with family any more. The family also noticed that Prasad liked to stay inside his room giving excuses for not helping his brother in the plantation. Even if he went to the plantation in the morning he would be back before noon offering various excuses for his early return.

His parents also noticed that Prasad was very suspicious of the food given to him and would check if he was being served, what all the other members were being served and if he had not seen his food being served he refused to eat it. Prasad’s personal hygiene also suffered. He had neglected his self-care. He had gone for days without bathing or shaving. His clothes had piled up and finally his mother started washing his clothes as he was not washing them.

On the day of the admission, Prasad’s grandmother had come home and had served him a plate of rice and had taken it into Prasad’s room. Prasad claims that he realised that the person who entered the room was not really his grandmother but was someone else pretending to be his grandmother. Prasad had taken the plate of rice and thrown it away and had tried to assault his grandmother. When the family heard the grandmother shouting they had run into Prasad’s room, making Prasad even more anxious and he finally had to be tied down to be brought under control.

Past psychiatric history

Prasad suffered from a similar episode about two and half years ago. He had developed poor sleep, irritability and had become suspicious of the neighbours, accusing them of performing malevolent charms against him. After many traditional healing methods were tried and proved unsuccessful, he had been admitted to a private hospital and was treated by a psychiatrist. The diagnosis card presented on that occasion, has a diagnosis of ‘acute and transient psychotic disorder’. He had been treated with Risperidone and Prasad had continued the treatment for 2 years following which, the drugs were tailed off about 2 months ago. He was functioning well after this episode and had completely recovered with the treatment.

Family history

He is the second child in a family of 4 children. His father, a 52 year-old labourer working at the Electricity Board is currently taking treatment for ischaemic heart disease. His mother, a 50 year-old housewife, is in good health. He has an elder brother who is

married and has one child. He has two younger sisters of 20 years and 18 years of age. All his siblings are in good health. His paternal uncle had suffered from a psychiatric illness suggestive of schizophrenia and was on long term treatment from the Kalubowila Teaching Hospital.

Personal History

Childhood

Prasad's birth and perinatal period was uncomplicated. His development had been age appropriate. He had difficulty adjusting to the school environment and his mother recalls he had suffered from separation anxiety. After these initial difficulties he managed to adjust to school and recalls a happy childhood with many friends.

He does not recall any physical, emotional or sexual abuse from his childhood.

Education and employment

He was a less than average student in school. He was not able pass his GCE O/L exams. He is able to read, write and do simple arithmetic. After leaving school he had worked at one of his uncle's shops in Bandaragama town as a helper. After a year, he tired of this work and had refused to continue.

Over the next few years, he was involved in several jobs but did not stay in one job for more than few months. He has been helping in his brother's plantation for the last 3 years.

He had shown no interest in having a girl friend, nor did he have any close male friends.

Current living circumstances

Prasad is currently living with his parents in their ancestral home in Bandaragma. All of his siblings including his married elder brother live in the same house. He is currently unemployed and receives a monthly allowance when the harvest is sold from the plantation.

Past medical/ surgical history

He had always been in good physical health. He has no history of head injury or seizures.

Substance use

Prasad consumes alcohol on social occasions. He smokes occasionally. He has used cannabis on rare occasions with his friends but never alone. He has never used any other substances.

Forensic History

Prasad has never had any involvement with law enforcement authorities.

Premorbid personality

Prasad has only had a few friends. He does not like spending time with friends. Apart

from his relatives and his immediate neighbours, he does not have many relationships. He is described as being a person who is very cautious of others and who does not trust others. Prasad enjoys watching films on video. He likes Hindi and Tamil films a lot. He claims to be a Buddhist but does not observe many of the rituals and does not go to the temple often.

Mental State Examination

Appearance and behaviour

Prasad was a young man of average build who looked disheveled with uncombed hair, unshaven face and crumpled clothes. His hands and feet were tied and he looked scared. He kept looking around the room and pleading with his parents not to kill him. When questioned he became more scared and refused to answer any of the questions. After he was reassured and an intramuscular antipsychotic was administered he calmed down and was more communicative. He avoided eye contact and was poorly accessible. Later, he became more accessible and was able to build up a satisfactory rapport.

Speech

Once he began to speak he spoke in a low volume, slowly. The volume and tone was raised when he talked about his persecutors. The speech was coherent and contents were relevant. There was no evidence of formal thought disorder.

Mood

His mood was predominantly anxious. He would become suspicious and tearful from time to time. The effect was not congruent with the thought content. He was not expressing any homicidal or suicidal ideas.

Thoughts

He firmly believed that he was being persecuted by a group of people who were being organised and controlled by his sister-in-law. He believed they were planning to kill him, that they spied on him and had on several occasions tried to poison him. These could be considered as persecutory delusions.

He believed that others in the neighborhood frequently talked about him. He had heard songs on the radio which had a special meaning for him and felt a message was being delivered to him. He was unable to elaborate on this but claimed that he was sure of this. This could be considered delusions of reference.

He believed that he is to receive blessings from the Ghana Deviyo. He believed he will receive great fortune following this blessing. These could be considered as delusions of grandiosity.

He believed that some of his family members have been replaced by identical looking persecutors. This is suggestive of delusions of misidentification.

He did not have thought echo, insertion, withdrawal or broadcasting, delusions of control or delusional perception.

Perception

He had third person auditory hallucinations. He heard his persecutor discussing him with the villagers and plotting against him. He clearly heard male and female voices, one voice he identified as belonging to his sister-in-law.

He did not experience thought echo, running commentary or somatic hallucinations.

Cognitive Functions

Attention and concentration:

Attention and concentration were normal and he recited the months of the year backwards without difficulty.

Orientation

He was able to recall the time of day, day of the week, date, month and year accurately. He knew that he was admitted to the National Hospital, Sri Lanka. He could identify the ward staff. Therefore, it was concluded that he was oriented in time, place and person.

Memory

His recent and remote memory was not impaired

Insight

He did not believe that he had a mental illness. He believed his experience was true and either others did not understand it or were pretending not to do so because they were also part of the group of persecutors. He was willing to accept treatment as he trusted doctors and believed that doctors would do him no harm.

Physical Examination

General examination

Height – 160 cm
Weight – 70 kg
Body mass index – 27.3
He was not pale.
There were no signs of nutritional deficiencies.
Hydration was normal.
Thyroid was not enlarged.

Examination of the cardiovascular system

Pulse – Rate 70 / min.
Rhythm and volume – Normal
Blood pressure – 110 / 70 mmHg.
Heart was in dual rhythm. There were no murmurs.

Examination of the respiratory system:
Respiratory rate – 22 / min
Breathing – Vesicular
No added sounds

Examination of the abdomen:
Liver and spleen - Not palpable
Kidneys – Not ballottable
There were no palpable intra abdominal masses

Examination of the central nervous system:
Motor system – Normal
Sensory system – Normal
Cerebellar functions - Normal
Cranial nerves – Normal
Higher cerebral functions – Normal
Funduscopy – Normal

Diagnostic Formulation

Summary

Prasad is a 24 year-old single unemployed person from Banadaragama. He presented with a change of behaviour with a conviction that he is being conspired against by his sister-in-law and neighbours over a duration of about 2 months, along with violent behaviour against family members over several days.

He has a past history of an episode of psychosis in 2007, for which he had been treated with risperidone. This treatment had been tailed off 3 months ago. He has a family history of schizophrenia.

The mental status examination revealed delusions of persecution, delusions of reference and delusions of grandiosity. He had third person auditory hallucinations. He did not have insight into his illness but was willing to undergo treatment.

The physical examination was unremarkable.

Initial Psychiatric Assessment

"History Taking"

Why Is History Taking So Important?

- It is the most important diagnostic tool to obtain information needed to make an accurate diagnosis and plan the correct management.
- This initial psychiatric assessment starts from the time a patient enters the interview room and continues until the client leaves the room.
- It depends on the Rapport; the relationship of mutual understanding or trust and agreement between you the psychiatry nurse and the client.

<u>History includes:</u>

- Demographic data: Name, Sex, Race, Marital status, Occupation, Address and living circumstance.
- Chief complaints
  - The patient's main problem or reason for the visit. This should be recorded as the patient's own words.
  - Ask leading questions such as:
    - "What brings you here today?"
    - "How can I help you?"
- History of the presenting complaint
  - This is the main part of the interview.
  - Gather basic information of specific symptoms, it is important to obtain a clear chronological account of symptoms (e.g. depression, psychosis) and the effects of these symptoms on behaviour.
    - Onset of symptoms: Abrupt, Acute, Insidious.
    - Course: Continuous, Episodic, Remittent.
    - Record aggravating or precipitating factors such as a failed romance, a death in the family, recently diagnosed serious illness, or stressors such as failure in exams or problems in relationships.
    - Include both pertinent positives and negatives.
- Past psychiatric history
  - Does the patient have a past history of psychiatric illness? When?
  - Was the illness episodic? Or was the patient continuously unwell?
  - Nature of treatment received, (hospital admissions, rehabilitations undergone etc.) and response to treatment? Why ?
  - Drug adherence? Information regarding follow up, reasons to default?

- Family history
    - 3 generation Genogram.
    - Family history of psychiatric illness.
    - Family history of medical illness, suicide or substance misuse in the family.
    - If a dependent, information about guardians, general information about siblings if any.
    - Interpersonal issues, social standing of the family, any other relevant information.
- Personal history
    - Birth and early development.
    - Disorders during childhood.
    - Schooling and school performances.
    - Occupational history.
    - Marital / Sexual history.
- Substance use
    - History of substance use: alcohol, nicotine, cannabis, other drugs of use
    - Duration of use: amount used at present and frequency of use
    - Associated problems (eg. legal/financial/social problems secondary to substance misuse)
- Forensic history: if patient has previously been in trouble with the police, or been convicted of anything.
- Past medical/surgical history.
- Allergy history.
- Pre-morbid personality
    - Social relationships
    - Prevailing mood
    - Attitude towards work and responsibility
    - Response to criticism and praise
    - Leisure activities and hobbies

Mental State Examination

This is a cross-section of the patients' psychological life and the sum total of the nurses' observations and impressions of that moment. Some parts of the MSE are obtained through simple observation of the patient's mental status while some parts require asking specific questions.

1. Appearance and behaviour
   - General appearance; evidence of self-care, grooming
   - Posture and movement, any sign of catatonic movements
2. Speech
   - Volume, rate, flow, content of speech
3. Mood
   - Anxious, Depressed, Elated, Irritable, Angry
4. Content of Thought
   - Pre-occupations and/or worries.
   - Ideas and plans of suicide
   - Obsessional ideas/impulses/images and compulsive rituals?
   - Delusions/overvalued ideas
5. Disorders of Perception: Illusions, hallucinations; auditory, visual, olfactory, tactile, gustatory
6. Cognitive Functions
   - Level of Consciousness
   - Orientation in time, place and person
   - Attention and concentration
   - Memory - short term and long term
   - Intelligence
7. Patient's understanding of illness/insight

<u>Appearance and Behaviour - General Appearance</u>

- Attitude toward the interview situation
- Consciousness
- Orientation
- Cooperativeness
- Rapport and attitude toward the interviewer

- Dress
- Attention span
- Catatonic signs

Clinical implications

  - *Dilated pupil: Drug intoxication*
  - *Pupil constriction: Narcotic misuse/dependence*
  - *Gaze shift/stooped posture: Depression*
  - *Unusual attire/colourful dress: Mania*
  - *Over familiarity: Mania,*

Psychomotor activity

  - *Level of activity: Lethargic, tense, restless, agitated*
  - *Type: Grimaces, Tics, Tremors*
  - *Unusual gestures*
  - *Disorders of motor activities*

- Tics:
  - Rapid irregular movements involving groups of facial or limb muscles
- Mannerisms
  - Abnormal and occasional bizarre performance of a voluntary, goal-directed activity
- Stereotypy
  - A negative and bizarre performance; not goal-directed
- Catalepsy
  - General term for an immobile position that is constantly maintained
- Catatonia
  - Syndrome characterised by cataleptic posturing, stereotypy, mutism, stupor, negativism, automatic obedience, echolalia and echopraxia.
- Akathisia: inability to seat/stand still

Clinical implications

- Excessive body movement (PM Agitation)
  - Anxiety, mania, stimulant abuse
- Psychomotor retardation
  - Depression, organicity, catatonic F20, drug induced stupor

Speech

- Tone
- Rate
- Volume
- Reaction time
- Coherent
- Relevant
- Disorders of speech
  - Pressure of speech: Rapid speech that is increased in amount and difficult to interpret
  - Poverty of speech: Restriction in the amount of speech
  - Dysarthria: Difficulty in articulation

Thoughts

- Delusion
- Overvalued idea
- Depressive cognition
- Suicidal idea

Disorders of form of thought

- Derailment: Thoughts slide on to a subsidiary content
- Substitution: Major thought is substituted by a subsidiary one
- Omission: Senseless omission of a thought or a part of it.
- Fusion: Heterogenous elements of thoughts are interwoven with each other
- Driveling: Distorted intermixture of constituent part of one complex thought (Evident through neologism, word salad etc.)

Disorders of stream of thought

1. Pressure of thought
2. Poverty of thought: A slowing down of the thinking process which hampers the formation of associations and may prevent the patient from reaching the original goal of his thoughts.
3. Thought blocking: The patient experiences a sudden break in the chain of thought *(Schizophrenia).*
4. Flight of ideas: A series of thoughts verbalized rapidly with abrupt shifts of subject matter with logical sequence. *(Mania as well as in organic mental disorders)*
5. Loosening of associations: A disorder of thinking and speech in which ideas shift from one subject to another with remote or no apparent reasons.

6. Perseveration: Repetitive behaviour or repetitive expression of a particular word, phrase, or concept during the course of speech.
7. *Circumstantiality:* The determining tendency is maintained but the patient can reach the goal only after having exhaustively explored all unnecessary associations arising in his mind.
8. *Tangentiality:* Expressions or responses characterised by a tendency to digress from an original topic of conversation, in which a common word connects two unrelated thoughts.

Clinical implications

- Circumstantiality:
  - Defensiveness, paranoid thinking
  - Schizophrenia/psychotic disorders
- Loosening of association
  - Schizophrenia/psychotic disorders
- Perseveration
  - Brain damage
- Word salad
  - Severe form of thought disintegration
  - Chronic psychotic illness

Disorders of content of thought

- Delusion
  - False unshakable belief, which is out of keeping with reality
- Overvalued ideas
  - Ideas which are reasonable and understandable in themselves but which come to unreasonably dominate the patient's life.
- Depressive cognition
- Suicidal idea

Types of delusions

1. Delusions of persecution: Being followed, harassed, threatened, or plotted against.
2. Delusions of grandeur: Being influential and important, perhaps having occult powers, or actually being some powerful figure out of history (Napoleonic complex).
3. Delusions of reference: External events or "portents" have personal significance, such as special messages or commands.
4. Delusions of love characterised by the patient's conviction that another person is in love with him or her.

5. Delusions of guilt: Delusional belief that one has committed a crime or other reprehensible act (Psychotic Depression).
6. Delusions of control: The core feature is the delusional belief that one is no longer in sole control of one's own body.
7. Hypochondriacal delusions founded on the conviction of having a serious disease.
8. Delusional jealousy: A delusional belief that one's partner is being unfaithful (Othello syndrome).
9. Delusional misidentification: A delusional belief that certain individuals are not who they externally appear to be. The delusion may be that familiar people have been replaced with outwardly identical strangers (Capgras syndrome) or that strangers are (really) familiar people (Fraegolisyndrome).
10. Delusions of thought interference: A group of delusions which are considered first rank symptoms of schizophrenia. They are thought insertion, thought withdrawal, and thought broadcasting.
11. Nihilistic delusion: A delusional belief that the patient has died or no longer exists or that the world has ended or is no longer real. Nothing matters any longer and continued effort is pointless. A feature of psychotic depressive illness.

Disorders of emotions

- Alexithymia:
    - Inability/difficulty in describing or being aware of one's emotion/mood (depression, substance abuse, PTSD).
- Anhedonia:
    - Loss of interest in, and withdrawal from all regular and pleasurable activities (Depression).
- Anxiety:
    - Feeling of apprehension caused by anticipation of danger, which may be internal or external.
- Bereavement
    - Feelings of grief or desolation, especially at the death or loss of a loved one.
- Blunted affect
    - Severe reduction in the intensity of externalised feeling tone (F20).
- Elation:
    - Mood consists of feelings of joy, euphoria, and intense optimism (mania).
- Flat affect
    - Absence/nearly absence of any signs of affective expression.

- Irritability:
  - Abnormal excessive excitability, with easily triggered anger, annoyance and impatience.
- Melencholia:
  - Severe depressive state.

Clinical implications

- Euphoria, elation, exaltation, ecstasy:
  - Mania
- Anxious/restlessness:
  - Depression/anxiety
- Sad, irritable, angry/depressed:
  - Depression
- Shallow, blunted, indifferent, restricted, inappropriate:
  - Schizophrenia
- Anhedonia:
  - Schizophrenia, Depression

<u>Perception</u>

A complex process of screening of physical signals by the sense organs and processing these data to represent reality.

- Imagery:
  - Awareness of a perception that has been generated within the mind. Imagery can be called up and terminated by an effort of will (voluntary).

Disorders of perception

- Illusion
  - Misperceptions of external stimuli (seen in anxiety and delirium).
- Hallucination
  - A true hallucination will be perceived as in external space, distinct from imagined images, outside conscious control, and as possessing relative permanence.

Types of hallucinations

- Auditory hallucinations - false perceptions of sounds (second person, third person).
- Gustatory hallucinations—false perceptions of taste.
- Olfactory hallucinations—false perceptions of smell.

- Visual hallucinations—false visual perceptions with eyes open in a lighted environment.
- Tactile hallucinations—false sensations of touch (Formication).

Clinical implications

- Any form of hallucinations:
    - Schizophrenia (72% auditory), affective disorders and organic mental disorders.
- Visual hallucinations
    - Suggestive of organic mental disorders but are seen in functional disorders.
- Gustatory, olfactory, and tactile hallucinations
    - Strongly suggest organic mental disorders.
- Tactile hallucinations
    - Common in drug and alcohol withdrawal and intoxication states.

<u>Cognitive Functions</u>

- Consciousness and Orientation
- Attention and Concentration
- Memory
- Judgement
- Intelligence

<u>Insight</u>

The patient's awareness of his disability and need for help.

Clinical grading of Insight

1. Complete denial of illness
2. Slight awareness of being sick and needing help but denying it at the same time.
3. Awareness of being sick, but attributing it to an external/physical cause.
4. Awareness of being sick due to something unknown in one's self .
5. Intellectual insight:
    - Awareness of being ill and that the Sx/failures in social adjustments are due to the patient's own particular irrational feelings/thoughts. Yet he does not apply this knowledge to current/future experiences.
6. True emotional insight
    - This is different from intellectual insight, in that awareness leads to significant basic change in future behaviour on a personal level.

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Psychopharmacology

History

Psychopharmacology as a method of treatment was not available prior to the 1950s and the focus of treatment centrered on behavioral interventions and sedatives. With the advent of psychopharmacologic agents, the number of in-patients dramatically lowered and thousands of patients were released from hospital care. Currently, psychopharmacology has become the primary treatment mode for psychiatric illnesses. Therefore, nurses are required to understand and update their knowledge on current advances in psychopharmacologic interventions as well as discoveries of new medications to treat mental illnesses. This new frontier of psychiatric thought, research and treatment greatly affects nursing practice. Medications are combined to find the most suitable treatments on an individual basis, which may require trying a number of alternatives before finding the right combination/s.

Antipsychotics

- Reducing as many of the psychotic symptoms as possible, enables the patient to participate more effectively in other forms of treatment.
- It may take 2-4 weeks to see improvement.
- Some people respond better to one drug than to another – idiosyncracy.
- Choosing the medication also depends on its side-effects - again, idiosyncratic.
- Half of the medicated people get side effects, therefore they discontinue the medication (loss of compliance or adherence).
- There are conventional (first generation) and second generation or atypical antipsychotics.
- Some patients respond better to conventional medication (e.g. Chlorpromazine), although atypical agents (e.g. risperodone) have been found to be more effective and safe in long-term treatment.
- Conventional (as well as some atypical) agents can have very serious side-effects e.g.: clozapine.

The most common side-effects of conventional antipsychotic medications include:

- Anticholinergic effects (an anticholinergic is a drug that inhibits the action of acetylcholine, the chemical transmitter by which the vagus nerve stimulates the stomach and intestines).
- Photosensitivity.
- Extrapyramidal side-effects (EPS).
- Akathisia: (Not being able to sit). Feeling restless or jittery, needing to fidget around.

- Dystonia: sudden muscle spasm characterised by torticollis (twisting of neck), opisthotonos (spasm of the neck and back forcing the head backwards), oculogyric crisis (a fixed gaze that cannot return to lateral).
- Parkinsonism: tremor, stiffness, rigidity, stooped posture, shuffling gait, akinesia (feeling slowed down), pill-rolling movement of fingers, oscillations of distal parts of extremities.
- Neuroleptic malignant syndrome: muscle rigidity, hyperpyrexia, hypertension, confusion, delirium.
- Tardive dyskinesia: involuntary movements of face and body (lip smacking, tongue protrusion, rocking, foot tapping), impaired gait and posture. Many of the cases are mild but the disorder can be socially disfiguring. The symptoms of frowning, blinking, grimacing, puckering, blowing, smacking, licking, chewing, tongue protrusion and spastic facial distortions are very troubling. Abnormal movements of the arms and legs also occur, including rapid, purposeless irregular movements; tremors and foot tapping. Body symptoms include dramatic movements of the neck and shoulders, rocking, twisting pelvic gyrations and thrusts. Because tardive dyskinesia is often irreversible, the goal is prevention. If symptoms begin to appear, the medication is reduced or the person is switched to a newer antipsychotic.

Psychopharmacology Antipsychotic medication side-effects

- Interference with sexual functioning is fairly common.
- Almost half of patients report weight gain.
- Identifying and managing side effects is important.
- Some people stop taking their medication and relapse, whereas others relapse first, and as a result, stop taking their medication.
- Monitoring white blood cells is essential with some medications, since agranulocytosis is common with some drugs and can be fatal, since the patient can easily succumb to an overwhelming infection.

Antipsychotic medication - Toxicity and overdose

- The primary symptom of overdose is CNS depression, which may extend to the point of coma.
- Other symptoms include agitation, restlessness, seizures, fever, EPS, arrhythmias, and hypotension.
- Caring for a client with overdose includes monitoring vital signs, especially of cardiac function; maintaining a patient's airway and gastric lavage.
- Antiparkinsonian medications may be given for EPS.
- They may induce seizures.

Administration of Psychopharmacology Antipsychotic medication

- Administration of antipsychotic medication is in oral, tablet/ capsule form, or by injection.
- Long-acting injectable medications such as fluphenazine decanoate and fluphentixol are often used to treat clients with schizophrenia.
- These medications are administered IM once every 3-4 weeks. A helpful regimen for clients who have difficulty remembering to take medications daily or who would otherwise be noncompliant.
- Psychopharmacology of Anti-depressant Medication and its Physiological effects
- The neurotransmitters involved in depression are dopamine (DA), serotonin (5-HT), norepinephrine (NE) and acetylcholine (ACH).
- It is believed that during a depressive episode, there is a functional deficiency of these neurotransmitters or hyposensitive receptors.
- Antidepressant medications increase the amount of available neuro-transmitters by inhibiting neuro-transmitter reuptake, by inhibiting monoamina oxidase (MAO) or by blocking certain receptors.

Antidepressant medications can be classified as:

- Older generation agents: tricyclics and monoamine oxidase inhibitors (MAOIs).
- New generation agents: selective serotonin reuptake inhibitors (SSRIs) and serotonin- norepinephrine reuptake inhibitors (SNRIs).
- he new generation medications have dramatically changed the treatment of depression, with more effective action and fewer side effects.
- Antidepressants do not cause dependence, tolerance, addiction or withdrawal.
- It takes an average of 10-14 days for the medication to start taking effect and the full effect may not be apparent for 4-6 weeks.
- When a client does not respond at all after a trial period of 4¬6 weeks, a different antidepressant is tried or a combination of other medications are tried.
- A significant number of clients improve when lithium is added to antidepressant treatment.
- For delusional or severely agitated clients ,antipsychotic medication may be indicated.

Side effects of anti-depressants

- Both tricyclics and MAOIs may have anticholinergic effects such as dry mouth, blurred vision, urinary retention and constipation.
- CNS effects include drowsiness, lethargy, insomnia and restlessness.

- Orthostatic hypotension and tachycardia may occur in the early phases of treatment
- The best known side effects are sexual dysfunction and weight gain.
- Some medications cause great sexual impairment and excessive weight gain, e.g. amitriptyline, clomipramine.
- Weight gain with tricyclic antidepressant medications are noted.
- The SSRIs and SNRIs have fewer anticholinergic effects, fewer cardiac effects, fewer sexual problems, less sedation and less weight gain.
- MAOIs decrease the amount of monoamine oxidase in the liver, which breaks down the essential amino acids tyramine and tryptophan. If a person eats food that is rich in these substances he or she risks hypertensive crisis.
- The first sign of hypertensive crisis is a sudden and severe headache, followed by neck stiffness, nausea, vomiting and tachycardia. Death can result from circulatory collapse or intracranial bleeding.

Food to avoid with MAOIs

- Absolutely restricted:
  - Aged cheeses; aged and cured meats; improperly stored or spoiled meat, fish or poultry; banana peel; broad bean pods; sauerkraut; soy sauce and stored beer.
- Consume in moderation:
  - Red or white wine (no more than two 4-oz glasses per day); bottled or canned beer, including non-alcoholic (no more than two 12-oz servings per day).
- The SSRIs and SNRIs increase the availability of 5-HT, which relieves depression but can also cause the hyperserotonergic state known as the serotonin syndrome (SS).
- This syndrome is more likely to occur when these agents are used in combination with MAOIs. SS develops very quickly and must be attended to immediately. Characteristic symptoms are: high fever confusion, hypomania, tachycardia, diaphoresis, disco-ordination and seizures.

Psychopharmacology Antidepressant medication toxicity and overdose

- Symptoms of toxicity are varied and must be noticed immediately.
- If MAOIs and other antidepressants are administered together, serious reactions may occur.
- CAUTION! Seven to 14 days should elapse between the use of MAOIs and other antidepressants.

Antidepressant Medication Administration

- Oral
- Usually takes 2-4 weeks to reach therapeutic levels
- Changes may be observed by others before the client recognises them

Psychopharmacology Antianxiety Medication Therapeutic effects

- Different medications are effective in various anxiety disorders.
- Individual benzodiazepines differ in potency, speed in crossing the blood-brain barrier, and degree of receptor binding.
- High-potency and short-acting benzodiazepines include alprazolam, lorazepam, oxazepam.
- Low-potency and long-acting benzodiazepines include clonazepam, diazepam and librium (chlordiazepoxide).
- Side effects of benzodiazepines are primarily related to the general sedative effects including drowsiness, fatigue, dizziness and psychomotor impairment.
- These medications potentiate the effects of alcohol and can lead to severe CNS depression.
- Intravenous administration can lead to cardiovascular collapse and respiratory depression.
- There is a potential for abuse in vulnerable client populations.
- Buspirone has no potential for dependence and does not potentiate the effects of alcohol on the CNS.
- It is the drug of choice for clients who are prone to substance abuse or for those who require long-term treatment with antianxiety medications.

Antianxiety medication - Toxicity and overdose

- Symptoms of toxicity include euphoria, slurred speech, disorientation, unsteady gait and impaired judgment.
- Symptoms of overdose include respiratory depression, cold and clammy skin, hypotension, weak and rapid pulse, dilated pupils and coma.
- These must be reported immediately!

Administration

- Antianxiety medications are taken orally and IM.
- Antacids interfere with the absorption of these medications and should not be taken until several hours later.
- Benzodiazepines should not be discontinued abruptly because of the risk of withdrawal symptoms. They should be reduced gradually and very slowly.

Mood stabilizers include a small group of diverse medications

- Lithium is the best known and most often prescribed mood stabilizer.
- In recent years, several anticonvulsant medications have been added to this category: carbamazepine and valproate and clonazepam.
- Calcium channel blockers are increasingly being used with success in manic disorders either alone or in combination with other mood stabilizers. They have been found to be effective in the treatment of bipolar disorder and seem to work best in people who also respond to lithium.

Mood-stabilizing medication - physiological effects

- The specific action of these medications is unclear.
- In the body, lithium substitutes for sodium, calcium, potassium and magnesium. It also interacts with neurotransmitters.
- Like antidepressants, lithium normalises Rapid Eye Movement (REM) sleep abnormalities which are present in mood disorders.
- Mood stabilizers are having an antimanic, antipanic and antianxiety effects.
- Their side effects include lack of spontaneity, memory problems, difficulty concentrating, nausea, vomiting, diarrhoea and hand tremors.
- Weight gain and a worsening of acne often persist throughout treatment.
- Women taking carbamazepine may have menstrual cycle irregularities and experience false positive pregnancy tests.
- Weight gain is the side effect which causes most complaints and is the major cause of discontinuing mood stabilizers.
- There is a fine line between therapeutic levels and toxic level of lithium.
- Mild lithium toxicity: serum level about 1,5 mEq/L (apathy, decreased concentration, slight twitching, coarse tremors).
- Moderate lithium toxicity: serum level about 1.5-2.5 mEq/L (severe diarrhoea, vomiting, tinnitus, blurred vision, tremors).
- Severe lithium toxicity: serum level above 2.5 mEq/L (nystagmus, dysarthria - speech difficulty due to impairment of the tongue, visual or tactile hallucinations, oliguria or anuria, confusion, seizures, coma or death).

Mood-stabilizing medication - Administration

- The administration of lithium is oral, in capsule or liquid form.
- Both carbamazepine and valproate are available in tablet and liquid forms. Initially low doses are increased gradually.
- The ultimate dosages are determined by reduction of symptoms, blood levels and side effects.
- Patients must continuously be monitored for hypotension and bradycardia.

Psychopharmacology Client Education in General

- One of the aims of client education is to reduce RECIDIVISM: the tendency to relapse into a previous mode of behaviour requiring readmission to a treatment programme
- Assess learning capacity - especially with chronically ill patients - and use the most relevant and appropriate teaching method.
- Explore cognitive, psychological, cultural, personal and social factors affecting attitudes and beliefs concerning medication

What nurses need to know for medication teaching

Psychosis

- Cognitive difficulties are secondary to thought disorder.
- Motivational problems are secondary to negative symptoms.
- Unpleasant side effects from medication.
- Persistence of positive symptoms (delusions) mitigating against adherence.

Mood disorders

- Persistent dysphoria leads to amotivation.
- Self-destructiveness – lethality.
- Manic irresponsibility.
- Loss of manic or hypomanic ego syntonic (identity-related) excitement.
- Unpleasant side effects from medications.

Anxiety disorders

- Addiction to antianxiety medication.
- Quick action of many antianxiety agents leads to positive reinforcement of increasing dosages.
- Lack of consistent provider knowledge of and expertise in application of effective non-medication treatment strategies for anxiety problems.

Personality disorders

- Addictive or abusive use of medications.
- Sensation seeking.
- Manipulation.

Teaching methods

- Present material that is clear, beneficial and interesting.
- Check the client’s information.
- Ask for verbal reiteration and demonstration of skills.

- Develop a “pre-test” and a “post-test” to evaluate level of knowledge and change in thinking/behaviour before and after learning experience

Teaching

- The nurse needs to be able to discuss the following questions with clients:

1. What does this medication do?
2. How should I take this medication?
3. What if I miss a dose?
4. What other medicine do not mix with this one?
5. What side effects can I expect?
6. Where can I keep my medication?
7. What do I do if I have a problem?

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2. *Stahl’s Essential Psychopharmacology: Neuroscientific Basis and Practical Applications*. S. M. Stahl, Stephen M. Stahl.. 4th Edition. UK: Cambridge University Press.

Module 2:
Basic Counselling and Core Communication Skills in Mental Health Nursing

Basic Counselling and Communication Skills in Building Effective Therapeutic Relationships with Clients and their Families

This module will provide an overview of basic counselling and communication skills including: active listening, empathy, psychological support, guidance, reflection and empowering clients. These communications and counselling skills are simple to learn and readily applicable regardless of the type of the patients and their family backgrounds.

One of the key skills a mental health nurse must possess is to be able to communicate effectively with patients and their families. Effective communication skills assist in building a good therapeutic relationship with patients as well as providing a platform from which to deliver a range of psychotherapeutic interventions. Nurses can become effective communicators by practising a set of communication techniques which are not difficult to learn but take a lot of practice and use in day-to-day work to master.

Basic counselling skills are essential to deliver effective nursing care in mental health. In mental health, the patient care does not end after discharging the client from the ward. There are many additional tasks to be done in planning their treatment follow up, such as providing health education to clients so as to build up a good drug compliance, talking to the families for supportive care etc. These counselling skills are useful in such circumstances. Therefore, having a basic knowledge of counselling skills is very important.

At the end of this learning session you will be able to:

1. Appreciate that communication is a two-way process and understand its basic principles.
2. Understand the different types of communication such as verbal, non-verbal and para-language.
3. Be an active listener and to be able to ask open and closed questions appropriately.
4. Be able to demonstrate empathy during communication.
5. Understand what is counselling and its basic components.
6. Practice skills that are useful in counselling and to use it in nursing care of the mentally ill.

Session outline

1. What is counselling and its place in mental health nursing?
2. Why is it important to understand that communication is a two-way process?
3. Understanding the difference between empathy and sympathy.
4. What is non-verbal communication?

5. Examples of good and bad non-verbal communication.
6. What is active listening and why is it important?
7. Active listening techniques - summarising, focusing, reflecting, paraphrasing.
8. What is the difference between therapeutic communication and normal communication?
9. What are open and closed questions? What is good and bad questioning?
10. Problem management in day to day nursing practice.

Role Play 1 - Bad non-verbal communication (How not to communicate)

The facilitator will act as the nurse and a volunteer from the audience can be the patient. During the first part of the role play, the student (the patient) tries to describe to the nurse how he/she had a difficult day during the last week. Following a discussion of about 5 minutes, the facilitator may ask the student who volunteered as the patient to describe to the audience how he or she felt during the conversation and then get the audience to point out all the bad non-verbal communication that was displayed during the role play. The facilitator (acting as the nurse) is expected to maintain a closed body (arms folded, legs across and looking away or looking down), be distracted, and look at his/her watch from time to time.

During the second part of the role play, the facilitator will demonstrate a better communication skill set by asking the same student or another volunteer to describe a difficult time he/she had over the last week. This will also be followed by questions to the volunteer as to how they felt during and after the interview and from the audience on the better non-verbal communication skills demonstrated during the interview.

During the last stage of the role play, the group will be divided into groups of 2-3 students and each will take turns being the nurse or the patient and practice good non-verbal communication using the same scenario.

Role Play 2 - Open and closed questions

The group will be advised to break into pairs and asked to practice open questions, while trying their best to avoid close ended questions. Open questions start with: where, when, what, which and how, while closed questions tend to begin with words such as why, is, which, were, etc. The facilitator(s) will move from group to group ensuring that each pair is capable of exploring open ended questions.

Role Play 3 - Showing empathy during a conversation

The facilitator will act as the nurse and the student volunteer will act as the patient. The nurse will listen to a difficult experience that the student had undergone during clinical practice (e.g. being assaulted by a patient, scolded by a superior, being threatened by a relative of a patient etc.). The facilitator will demonstrate active listening and different ways of showing empathy during this conversation. The facilitator will demonstrate

different forms of active listening, validating the student's view, being non-judgmental and trying to explore the student's point-of-view about what happened to him/her.

Video

A 15 minute video will be shown of a nurse communicating effectively with a client using all of the techniques discussed during the session (drug refusal and a talkative patient).

Some case scenarios to discuss

1. A hallucinating, distracted patient - Kamala is having a diagnosis of schizophrenia. She has been admitted following a relapse. Kamala is experiencing auditory hallucinations in which she hears that the doctors and the nurses in the ward will kill her. The nurse is trying to engage Kamala to take her medicines.

2. An angry patient - Nimal is recovering from a relapse of schizophrenia. He was discharged during the ward round today. However, it is close to 2 pm now and the doctor has not written up his diagnosis card yet. His family has been waiting outside the ward from 12 noon to take him home. Nimal is very angry and he is demanding that you send him home.

3. A talkative patient - You are trying to finish up your documentation to finish your shift, when Gayan comes towards the nursing station. Gayan likes talking to nurses and doctors. He begins to talk about his school days and how he knew someone just like you in his school. You need to finish the documentation and leave on time, as ýou have a doctor's appointment for yourself/your child.

4. A sad and anxious patient - Nethmi is suffering from treatment resistant depression. She has been admitted for a course of Electro Convulsive Therapy (ECT). Nethmi has never undergone ECT before. She is very anxious. The doctor has asked you to communicate with Nethmi the side effects associated with ECT

5. A manic patient - Seetha is experiencing a manic relapse of her bipolar illness. She believes that the president is going to marry her. Another patient on the ward has challenged her belief and this has made Seetha very upset. She is asking you to tell the patient who challenged her that she is fact the future first lady of the country.

6. A guarded and paranoid patient - Gamlath is suspicious about his wife's fidelity. He believes that she put him in hospital so that she can have contact with her lover without any interference. He is suspicious and angry with the hospital staff for believing his wife and admitting him against his wishes to hospital. You are trying to explore his beliefs about his wife and trying to get an idea about the risk he poses to her. Gamlath is very guarded.

7. A scared patient - Sunimal is having his first episode of psychosis. He sees his environment as threatening. He hears hallucinatory voices telling him that he would be killed soon. He believes that the medication that is being given to him is poison and will kill him. He has tried to escape from the ward twice today. You are trying to reassure him.

Understanding and Dealing with Aggression

Anger is one of the fundamental emotions. But it turns into aggression when it exceeds normal levels. Many mental illnesses and substance abuses are associated with aggression. Aggression may lead individuals to act against self and/or others.

An acutely disturbed patient is one of the most commonly encountered psychiatric emergencies a mental health nurse will have the deal with. Managing an acutely disturbed patient requires quick thinking as well as a range of skills that need to be practised and kept up to date. There are many treatment modalities available today that can be used to calm down an aggressive patient. The risk of injury to staff as well as the patient is very high during the process of managing an aggressive patient.

A patient may become disturbed due to a variety of reasons. Despite the variety of reasons whereby a person may become disturbed, common principles are employed in the management of such aggression. These common principles ensure the safety of both the patient and staff members involved.

Objectives:

At the end of the training, the participants will be able to:

1. Acquire adequate knowledge and skills to identify and assess an aggressive patient.
2. Deal effectively with patients with aggression, and initiate appropriate remedial steps.
3. Pre-empt aggression and take necessary nursing management to prevent aggressive behaviour.

Curriculum:

1. Understanding what aggression is.
2. Knowing common mental health conditions which cause aggression.
3. Understanding circumstances which trigger aggression (provoked aggression).
4. Understanding factors which minimise development of aggression.
5. Acquiring knowledge and skills to manage aggression.
6. Identify the role of the nurse in crisis intervention.
7. Know the different break away skills used in a crisis and be able to use them in an emergency.
8. Know when to call for help.
9. Options available to control an acutely aggressive patient.

   a) Mechanical restraints

   b) Chemical restraints

   c) Seclusion

10. Ethical and legal implications of the methods used to control acutely disturbed patients.
11. Dealing with patient and staff following an episode of aggression.
    a) Psychological consequences of trauma
    b) Debriefing of staff involved in the incident
    c) Peer support for staff and patients

Critical thinking questions

Lalani is a 28-year-old lady who is a garment factory worker from Katunayake. She developed her first manic episode 2 months ago and was treated in the hospital psychiatry ward for 3 weeks. On the day of admission Lalani started demanding to go home. The nurses and doctors have explained to Lalani that she needs to stay in hospital until she is better. Lalani becomes aggressive at this point. She throws her belongings around the hospital and hits the patient who is in the next bed. The doctor requests the ward nurses to restrain her and to administer 10mg of Haloperidol and Midazolam to her. Lalani starts threatening that she will hit anyone who comes near her. She also threatens to harm herself if she is not allowed to go home.

1. What are your immediate concerns about Lalani?
2. What are risks associated with restraining Lalani and administering medication to sedate her?
3. What are the alternatives to management suggested by the doctor?

<u>Role play 1:</u>
A patient (a participant) suddenly shows restlessness and it is noticed by a nursing staff (a participant).

<u>Role play 2:</u>
A nursing officer (a participant) notices a patient (a participant) has failed to take a shower. The nursing officer forces the patient to do the expected. The patient suddenly turns into aggressive.

Further Reading:

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Improving Parenting Skills for Child and Adolescent Mental Health Wellbeing

Childhood and adolescent period mental health issues have different manifestations. These periods form the platform for mental wellbeing in later life. Careful and unique approaches will equip children and adolescents to acquire healthy psychological development and prevent/act against mental health issues in these periods and in later life.

Objectives:

At the end of the training, the participants should have developed:

1. Knowledge on children's and adolescent behaviours and child and adolescent mental health issues.
2. Knowledge and skills in parenting to positively accommodate/integrate children/ adolescents in day to day life and address their concerns.
3. The ability to identify autism.
4. Parenting skills.

Curriculum:

1. Understanding challenges in mental wellbeing during childhood and adolescent periods.
2. Understanding why these periods contend importance.
3. Knowing risks and common mental health problems associated with these periods.
4. Understanding the importance of a supportive environment and positive re-inforcement and why punishment/confrontation should be avoided.
5. Knowing what good parenting skills are and their practical implication.

Role Play 1:
A son (a participant) becomes uninterested in education. The mother (a participant) tries to find the cause.

Role Play 2:
A 10 year-old girl shows a tendency to shout at others when her needs are not met. How can this issue be managed?

Study Material 2

What is Counselling?

Counselling involves listening. Counselling is not about giving advice!

What can Counselling Provide for the Mentally Ill?

- A safe space to be heard - the client tells his/her whole story.
- A way to understand his/her own distress.
- Someone who will listen without blaming or judging.
- Respect.
- Validation of feelings.
- An opportunity to explore practical options with her.
- An opportunity to look for solutions to her problems.
- Support.

What is the process of counselling?

- Opening: establishing a relationship / building trust.
- Exploring: good listening.
- Understanding: clarifying / reflecting / summarising the problems.
- Deciding on intervention: understanding the situation that the woman is in.
- Exploring the problem to find solutions.
- Helping the woman to plan her own solutions.
- Monitoring and maximising resilience.

Helping Others

Health workers often see distressed clients and their families. It is not always easy to know how you can help or what to do.

What we need to understand:

- It is very difficult to know about other people's lives.
- Your experiences shape who you are - and it is not easy to understand something from another's point of view.
- There are many ways of seeing and experiencing the world and these depend on our upbringing and beliefs.
- We need to be able to respect another person's point of view, even if it is different from our own.

- We need to recognise differences and similarities between people.
- It takes a lot of thinking about yourself before you can understand something from another's point of view.

Understanding yourself

When you are trying to help someone who is distressed, it can be very upsetting for you. It is very important that you try and think about how you feel so that you can help the other person in the best way. This is called 'self-reflection'.

The following are important points on self-reflection:

- Try to give yourself time - every day - to think about how you feel and why.
- When working - try to monitor what you feel, and ask where the feelings come from.
- Try to notice when you feel very strong feelings about something.
- Try to think about some of your strongest feelings, and see if they link to any of your own experiences.
- Treat your own feelings with the same compassion and respect you would give to others.

Empathy

The terms empathy and sympathy are both about feeling for somebody else's situation, but they often get confused. Empathy is:

- Putting yourself in someone else's shoes.
- Respectfully imagining what someone else's life is like.
- Entering into the private world of another person, without making judgements.
- Empathy is showing that you understand the person's experiences, behaviour and feelings.

How do you show empathy?

It is hardest to empathise with those who are different from us. In order to empathise with another, you need to be:

- *Open-minded:* you must set aside, for the moment, your own beliefs, values and attitudes in order to consider those of the other person.
- *Imaginative:* imagine the other person's background, thoughts and feelings.
- *Committed:* want to understand another person.
- *Knowing and accepting of yourself:* knowing yourself and accepting who you are helps to develop empathy for others.

Difference between empathy and sympathy

- *Empathy:* Putting yourself in another's shoes and trying to see the world though their eyes. This does not mean that you feel exactly what they are feeling or that you have been through everything they have been through.
- *Sympathy:* Feeling what another person is going through. For instance, feeling the sadness a family is feeling from the loss of their child.

A helper needs to feel empathy, because you cannot possibly experience everything that people go through. You use your experiences, and your attention to understand the other person's situation.

Communication Skills

In order to learn how to be helpful to someone in distress, there are some useful counselling skills which are outlined below. The more the skills are practiced, the easier they are to use.

Listening Skills

Active listening

Active listening happens when you "listen for meaning". The listener says very little but conveys empathy, acceptance and genuineness. The listener only speaks to find out if they have heard or understood correctly.

Key points about empathic listening:

- Listening is active.
- There is more to listening then simply not talking, or lending your ears to somebody.
- There are verbal and non-verbal components to listening. You can listen without saying anything.
- Listening involves more than just one sense. It is not just hearing with your ears, but also involves observing with your eyes and saying things at times. It can include touch as well.
- Active listening is also communicating what you have heard and understood.

Why should we use active or empathic listening?

- Empathic listening encourages clients to talk more about their issues. This allows you as a helper to gain a better understanding of the difficulties and understand their view of the world.
- It leaves the client with the understanding that he/she has been heard. Just the experience of being heard can be healing.
- Active listening helps establish a relationship between client and you.

Verbal listening

Minimal verbal response: These are verbal responses showing that you are listening. Verbal responses include: "mmm...mmm," "uh-huh," or "yes."

These minimal responses show the man/woman that you are listening to him/her, and encourages him/her to continue talking.

Non-verbal listening

The SOLERF method is a useful way to "listen" without speaking.

Squarely face person - not turned to the side.

Use **Open** posture without crossed arms and legs.

Lean slightly toward the person rather than sitting back in the chair.

Use **Eye** contact instead of staring off into deep space.

Relax, keep it natural instead of sitting like a board.

Look **Friendly** and welcoming rather than neutral or scowling.

Remember:
Communication is 55% body language, 38% tone and 7% words. Your client may not remember what was said, but they will remember how you made them feel.

Non-verbal behaviours include: showing it in your face, for example facial expression, looking interested and concerned; maintaining good eye contact, showing it in your body movements, for example nodding of head, leaning forward.

Listening to non-verbal communication

Much of the communication that takes place between people is non-verbal. Our faces and bodies are extremely communicative. Being able to read non-verbal messages or body language is an important factor in establishing and maintaining relationships (Carton et al., 1999).

Body language includes many different aspects of non-verbal behaviour, including:

- eye contact such as staring, avoiding eye contact
- facial expressions such as frowning, smiling, clenching or 'biting' lips, raising eyebrows
- voice, such as tone, volume, accent, inflection, pauses
- body movement, such as posture, gestures, fidgeting
- physiological responses, such as perspiring, breathing rapidly, blushing
- appearance, such as dress.

In practice, both clients and mental health nurses send many messages and clues through their non-verbal behaviour. It is therefore important that mental health nurses are aware of their own non-verbal body language before they can explore clients' non-verbal behaviour. In practice, however, we may not always be aware of the non-verbal messages that we communicate and, more importantly, how they might affect our interactions and relationship with clients, their families and work colleagues.

Non-verbal communication either on its own or together can influence verbal communication in the following ways:

- Confirm what is being said verbally, for example when talking about the recent death of her father, the client looked sad and became tearful.
- Confuse what is being said, for example when telling the client she wanted to hear his story, the nurse kept looking at her watch and fidgeting with her pen.
- Emphasise what is being said verbally, for example when talking about his anger towards his family for 'forcing him to come into hospital', the client clenched his fist and banged the table.
- Add intensity to the verbal message, for example when asking for extra medication to stop the voices, the client stood up and put his hands over his ears and shouted 'I want them to stop, I want them to stop'.

Asking questions

The questions we ask - open and closed - are important for counselling. They can help a person open up or close them down.

Open question: is used in order to gather lots of information - you ask it when you want to get a long answer.

Closed question: is used to get specific information - it can normally be answered with either a single word or a short phrase.

Open questions

Open-ended questions have no correct answer and require an explanation.

For example:

- What brought you in here today?
- How do you feel about this pregnancy?
- How does that make you feel?

Open Ended Questions are good for:

- Starting the information gathering part of the session
- Keeping the client talking

Closed questions

Closed questions are those that can easily be answered with a "yes" or a "no" or brief information.

For example:

- What is your name and date of birth?
- Is this pregnancy planned?
- Where do you work?
- Are you ready to stop doing that?

Closed questions are useful for:

- Getting necessary information
- To help the client to focus their discussion.

Unhelpful questions

Unhelpful questions include the following.

Some closed questions

These are questions that limit the other person's options and often only give the option of a 'yes' or 'no' response, for example:

- Did you take your medication?
- Have you seen the doctor?
- Do you hear voices?
- Did you go to the hospital?
- Do you like your parents?

Although closed questions are useful when gathering information, they have limited value and do not encourage dialogue, and as a result reduce the opportunity to engage with the client. Overuse of closed questions can also set up a pattern of 'questions and answers', which can be hard to break.

Other questions, which are unhelpful in encouraging dialogue and person-centred communication, include the following.

Leading questions

As the name suggests, these questions involve imposing your own perspective or being suggestive, for example 'I don't think you are very happy with your husband?' rather than, 'How do you feel towards your husband?', which encourages person-centred communication rather than nurse-led communication.

Multiple questions

These involve asking two or more questions at once, for example 'What did the doctor say when you told him about your panic attacks; did he suggest reviewing your medication and did he refer you to the anxiety management group?' It is not surprising that this can be confusing and unhelpful for the client. In addition, when the client answers, the mental health nurse will not know which question the client has answered.

The 'why' question

The 'why' question tends to invite an answer rather than a description or an exploration. In addition, the use of 'why' may appear interrogative and as a

result may evoke a defensive answer from the person. For example, how might you feel and respond if you were asked the following 'why' questions: 'Why were you late?'; 'Why did you say that?' Such questions may cause the person to feel defensive and/or irritated. Therefore, it may not be surprising that the following why question might evoke such a limited response:

Nurse: 'Why didn't you take your medication?'

Client: 'Because I forgot.'

Reflection skills

Reflecting acts like a mirror; it gives back to the patient what he/she has just communicated to us. It lets the patient know what you understand about what he/she has shared and communicates empathy.

Importance of reflecting

- Relationship building: reflecting is valuable in building a relationship with the patient by communicating trust, acceptance and understanding.
- Clarification: reflecting is helpful for the patient to be able to clarify for themselves their problems and feelings.
- Information: reflecting helps the counsellor get information about the patient and how he/she views his/her situation.
- Verification: reflecting helps the counsellor to check his/her perception of what the patient communicates.

There are four different reflecting skills. These are skills that can be used at any stage in the counselling session, but are really important for building trust and exploring the problem.

- Reflecting feelings
- Restating/reframing
- Affirmation
- Summarising

Reflecting feelings

Reflect what the client is feeling. Focus on feelings, NOT the details of what is said

Tips for reflecting feelings:

- Listen for and reflect both verbal and non-verbal communication of feelings.
- Read body language and reflect what you see if feelings are not expressed verbally.

Restating/rephrasing

This is saying what you understand the patient to be communicating. By doing this you are letting him/her know that you understand and, if you don't, are willing to be corrected.

Tips for restating:

- Use your own words to explain your understanding of what the patient is saying.
- Use slightly different words that have the same meaning; do not just repeat what he/she said.
- Rephrase both content and feelings.
- Convey empathy, acceptance and genuineness.
- Be tentative and respectful, i.e. "I hear you saying...," or "It sounds like..."

<u>Affirmation</u>

This encourages the client in the choices he/she has made. Affirmation can be for choices, knowledge or behaviour.

- This skill is very similar to how a teacher affirms or verbally rewards a learner, or how a parent might encourage a child by saying "well done" or "you have done a good job" or "you have done your best."
- This may begin with the counsellor affirming the client for choosing to come for counselling.

But, unlike the affirmation of a teacher to a learner, the key skill of affirmation in counselling is encouraging the patient to affirm himself/herself; this is something the client can do for himself/herself, rather than depend on the counsellor for affirmation.

For instance, instead of saying, "I am so proud of you for coming back to get your test results," the counsellor should say, "You should be very proud of yourself for ...returning for your results" or "...for making the choice to use a condom this weekend."
Affirmation is an important skill for empowering clients; by affirming them, we are encouraging men/women in the healthy decisions and behaviours they have chosen and helping them to continue making similar choices.

<u>Summarising</u>

Summarising highlights the most important areas, feelings, or themes of what the patient has been saying.

Usefulness of summarising:

- Draws together the important points and makes them clear.
- Reviews the session, then briefly describes the most important points and says what could be covered next time.

Paraphrasing

Involves expressing the person's core message in your own words. When using paraphrasing, essentially the meaning is not changed but the words are different. Paraphrasing is a valuable tool in that it demonstrates to the client that the mental health nurse is listening and has heard what s/he has said, which can feel very supportive and therefore therapeutic. Paraphrasing can also be used to check clarity and understanding rather than using questions,

> Remember, the person may forget what you said, but will never forget how you made them *feel*.

Containment

When feelings are painful and overwhelming, the client may need someone to help him/her to hold and understand those feelings.

When you work with feelings, it helps if you understand:

- that the feelings that you have when you work with people are valuable clues about how they may feel.
- that getting to understand your feelings can take time. We need to have patience with ourselves and other people
- that if your own jug is too full, you will not be able to hold someone else feelings as well.

Counselling as an intervention

Counselling may be used to:

- Provide containment
- Offer supportive suggestions
- Offer encouragement and sensitive advice
- Explore the problem and resolve these with new skills and support systems
- Explore how childhood problems may be affecting pregnancy and being a mother (this usually requires a lot of counselling skill and time)
- Bring closure to unresolved issues
- Provide information on emotional or physical aspects of pregnancy, birth and post-partum.
- Provide information on infant emotions, responses and resources available
- Provide referral to a specialist, if necessary

Problem management

Managing problems is only possible if the counsellor and client have lots of time together. This can't be done in one session. In order to help the client cope with her problems, it is important to understand how each person fits into the environment around them. This mother may be part of a family, a community and a society that could help her. On the other hand, those around her could be part of the problem.

There are several possible steps to managing problems:

- Understanding the problem
- Looking at options
- Setting goals
- Developing a plan of action
- Monitoring and evaluation

Understanding the problem

There may be many solutions to a problem, but in order to understand what will work best for the client, all the parts of the problem must be understood. Some issues may be hidden.

Looking at options

The counsellor helps the client to list the parts of the problem, and prioritise what needs to be dealt with first. Then the counsellor and client can discuss how the problem could be managed. The counsellor and client talk about different ways of putting solutions into action. Each option will have advantages and disadvantages.

Setting goals

The counsellor helps the client to decide on simple goals that may be successfully achieved. Smaller goals may lead, over time, to reaching larger goals.

Developing a plan of action

The client needs to decide what will work best for him or her - and the counsellor helps to draw up a plan of action. The client should feel empowered that the actions she chooses will help her to reach the goals.

Monitoring and evaluation

When the client carries out the plan of action, both client and counsellor need to talk about how effective the action plan has been. They meet to look at how things are going, and look for solutions to any new problems that might occur. The counsellor provides support as they work through the steps of problem management again. Where appropriate, the woman is affirmed for her choices or actions.

Even when you have practiced all the skills and approaches to dealing with clients in distress, it is sometimes difficult to know how to respond when.

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Nursing Management in Aggression

Nurses providing care for patients who are acutely ill with behavioural disturbances face a true challenge. These nurses work in settings such as psychiatric emergency rooms, acute wards and other wards where patients with aggressive behaviors can pose a significant risk to themselves, other patients and health care providers. Thus preventing and managing behaviour are important skills that all nurses including psychiatric nurses need to acquire.

General Principles of Management

- The safety of patient, clinician, health staff, other patients and potential intended victims is of the most importance while looking after aggressive patients.
- The doors should open outwards and not be lockable from inside or capable of being blocked from inside.
- While working with impulsively aggressive or violent patients in any setting, one must take care to reduce the patient's accessibility to movable objects, any object that can be used as a weapon and attire that might add to the risk of injury during an assault, including neckties, necklaces, earrings, eyeglasses, lamps and pens.
- Adequate clinical and supportive staff training and the availability of appropriate supervision and observation are critical safeguards in the treatment of potentially aggressive patients.
- The mental health nurse may choose to present in a calm and firm but respectful manner, putting space between self and patient; avoiding physical or verbal threats, false promises and must work to build rapport with client.
- For health staff members who are treating patients with a high risk for violent behaviour, training in basic self-defense techniques and physical restraint techniques are useful.

Drug Treatment in Aggressive and Violent Behaviours

Careful diagnosis has to be made to avoid overuse and misuse of medication. Medications are used primarily for 2 purposes:

- To use sedating medication in an acute situation to calm the client so that client will not harm self or others.
- To use medication to treat chronic aggressive behaviour.

Factors influencing choice of a drug –

- Availability of an IM injection.,
- Speed of onset and previous history of response.

Acute Agitation and Aggression

Antipsychotic – It is often the sedating property of the antipsychotic that produces the calming effect on the client. The most common drug in use in our wards is Haloperidol 5 mg or 10 mg given IM.

Benzodiazepines is used due to the sedative effect and rapid action. Most commonly used are Midazolam or Diazepam, administered orally or through IM injection.
Other sedating agents used include Valproate, Promethasin and Olanzepinerapi tab.

Chronic Aggression

When a client continues to exhibit aggression for more than several weeks, the choice of medication is based on the underlying condition (i.e. if related to schizophrenia-antipsychotic).

- Antipsychotic - Olanzapine, Haloperidol, Chlorpromazine etc.
- Anxiolytics and mood stabilizers - Lithium, Carbamazepine and Valproate to treat bipolar associated aggressive behaviour.
- Antidepressants – tricyclics
- Antihypertensive medication – Propanolol to treat aggression related to organic brain syndrome.

The Nursing Process

Nursing Assessment

- Establish a therapeutic alliance with the patient.
- Assess the patient's potential for violence.
- Following the assessment, if the patient is believed to be potentially violent, the nurse should:
  - Implement the appropriate clinical guidelines to provide for patient and staff safety
  - Notify co-staff members
  - Obtain additional help and security if needed
  - Assess the environment and make necessary changes.
  - Notify the consultant psychiatrist and assess the need for prn medications.

Nursing Interventions

Nursing interventions range from preventive strategies such as self-awareness, patient education and assertiveness training to anticipatory strategies such as verbal and nonverbal communications, and the use of medications. If the patient's aggressive behaviour escalates despite these actions, the nurse may need to implement crisis management techniques and containment strategies such as seclusion or restraints.

Self-awareness

It's important to know about personal stress which can interfere in one's ability to communicate with patients. Anxiety, anger, tiredness, apathy, personal work problems etc. on the part of the nurse can affect the patient. Negative counter transference reactions may lead to non-therapeutic responses on the part of the staff. Ongoing self-awareness and supervision can assist the nurse in ensuring that the patient needs rather than personal needs are satisfied.

Patient Education

Teaching patients about communication and the appropriate way to express anger can be one of the most successful interventions in preventing aggressive behaviour. The nurse can then work with patients on ways to express their feelings and evaluate whether the responses they select are adaptive or mal adaptive.

Assertiveness Training

Assertive behaviour is a basic interpersonal skill that includes the following:

- Communicating directly with another person.

- Say no to unreasonable requests.
- Being able to state complaints.
- Patients with few assertive skills can learn them by participating in structured groups and programmes. In these settings, patients can watch demonstrations of specific skills and then role play the skills themselves.
- Staff can provide feedback to patients on appropriateness and effectiveness of their responses.

Communication Strategies

- Nurses have to:
- Present a calm appearance.
- Speak softly in a non-proactive and non judgmental manner.
- Speak in a neutral and concrete way to put space between yourself and patient.
- Show respect to the patient.
- Avoid intense direct eye contact.
- Demonstrate control over the situation without assuming an overly authoritarian stance.
- Facilitate the patient's stance.
- Listen to the patient and avoid early interpretations
- Do not make promises that cannot be kept.

Seclusion

Seclusion is the involuntary confining of a person alone in a room from which the person is physically prevented from leaving (Brown, 2000). The degree of seclusion varies. It includes confining a patient in a room with a closed or unlocked door or placing a patient in a locked room with a mattress but no linen and with limited opportunity for communication.

The rationale for the use of seclusion is based on 3 therapeutic principles:

- ***Containment*** – using this principle, patients are restricted to a place where they are safe from harming themselves and other patients.
- ***Isolation –*** addresses the need for patients to distance themselves from relationships that, because of illness are pathologically intense. Some patients, particularly those with paranoia, distort the meaning of the interactions around them. Their distortions create such psychic pain that seclusion may provide some relief and maybe the only place to feel safe from their "persecutors".

- The third principle is that seclusion provides **a decrease in sensory input** for patients whose illness results in a heightened sensitivity to external stimulation. The quiet atmosphere and monotony of a seclusion room may provide some relief from the sensory overload.

Restraints

Indications – used when the client:

- is no longer exerting control over his/her own behaviour.
- to prevent harm to others and to the patient
- to prevent serious disruption of the treatment environment.

Physical restraints are any manual methods applied to the patient's body that she/he cannot easily remove and that restricts freedom of movement or normal access to one's body, material or equipment (Brown, 2000).

Chemical restraints are medications used to restrict a patient's freedom of movement or for emergency control of behaviour, but it is not a standard treatment for the patient's medical or psychiatric condition (Murphy, 2002).

Chemical restraints are always encouraged over physical restraints. Since seclusion and restraints represent restriction of patient freedom and can result in harm to both the patient and the staff who implement them, **they should be used only as an emergency** intervention to ensure the safety of the patient or others and only when other less restrictive interventions have been ineffective. They are a violation of patient rights if used as a means of coercion, discipline or convenience of staff (Brown, 2000).

Guidelines for the Use of Restraints

1. Restraints must not be used to punish a patient or solely following the convenience of staff or other patients.
2. Staff must take into consideration the medical/psychiatric status of the patient.
3. A written policy must be followed.
4. In non-emergency situations, physical restraints should be used very sparingly and only after careful and comprehensive review, assessment and documentation provides substantial evidence that no safer alternative or setting can be found to prevent their use.
5. All mechanical restraints must be padded to decrease the chance of pressure damage and abrasion to skin and underlying tissues; proper size and type must be used.
6. Both the patient and restriction must be checked frequently and restraints removed periodically. A restrained limb should be periodically exercised and,

if possible the patient should be ambulated at reasonable intervals. Attention to the need for hydration, elimination, comfort, and social interaction must be assured.

7. Behaviour that precipitates a decision to restrain a patient should first trigger investigation and treatment aimed at understanding and eliminating the cause of the behaviour.
8. Nursing staff should observe the patient every 15 min.
9. All the needs of the patient must be met with caution.
10. With four point restraints, each limb should be released or the restraint loosened every 15 minutes.
11. The patient should be gradually decreased from seclusion or restraint. The patient should not be made to feel guilty after being released from restraints of his past behaviour.
12. Documentation is necessary.

Risks with Restraints

Falls, strangulation, loss of muscle tone, pressure sores, decreased mobility, agitation, reduced bone mass, stiffness, and frustration, loss of dignity, incontinence, and constipation.

Terminating the Intervention

Patients should be removed from seclusion or restraints as soon as they meet the criteria for release. It is important to review with the patient the behaviour that precipitated the Intervention and the patient's current capacity to have control over his/her behaviour. Patients should be told which behaviours or impulses they need to exhibit and which intervention they need to control before the intervention can be discontinued. Communication and careful documentation are critical in making an accurate assessment of a patient's level of control.

Debriefing

Debriefing is an important part of terminating the use of seclusion or restraints. Debriefing is a therapeutic intervention that includes reviewing the facts related to an event and processing the response to them. It provides the staff and patient with an opportunity to clarify the rationale for seclusion, offer mutual feedback, and identify alternative methods of coping that might help the patient avoid seclusion in the future.

Staff Support

Nurses can be supported by allowing adequate time off from work to address their physical and emotional needs. Discussing the event in a non-blaming manner is also

helpful. Validation from others that assaults occur despite clinical competence and appropriate interventions can help the assaulted nurse in healing.

Conclusion

Anger is a normal human emotion that is crucial for an individual's growth. When handled appropriately and expressed assertively, anger is a positive creative force that leads to problem solving and productive change. When channeled inappropriately and expressed as verbal aggression or physical aggression, anger is destructive and a potentially life threatening force.

Psychiatric nurses in particular, work with patients who have inadequate coping mechanisms for dealing with stress. Patients admitted to an inpatient psychiatric unit are usually in crisis, so their coping skills are even less effective. During these times of stress, acts of physical aggression or violence can occur. Further, nurses spend more time in the inpatient unit than those from any other disciplines, so they are more at risk of being victims of acts of violence by patients. For these reasons, it is critical that psychiatric nurses be able to assess patients at risk for violence and intervene effectively with patients before, during and after an aggressive episode.

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Parenting Skills for Good Child and Adolescent Mental Health

As children grow, they experience physical, mental, social, and emotional changes. Learning about each of these stages can help prepare you for the challenges and opportunities of parenting teenagers.

Middle Childhood (6-8 years old)

By this time, most children can dress themselves, catch a ball, tie their shoes, and begin developing independence from the family. They start school and come into regular contact with the world. You may see children show more concern for others, be able to describe experiences, and talk about thoughts and feelings.

What You Can Do...

- Talk with your child about school, friends, respect, and things they look forward to in the future.
- Help your child set achievable goals.
- Make clear rules and stick to them. Be clear about what behaviour is OK and not OK.
- Get involved with your child's school.
- Do fun things together as a family, such as playing games and going to events.

Middle Childhood (9-11 years old)

During later childhood, friendships become more important, and skills and confidence develop. Your child may experience more peer pressure and face academic challenges at school. This is an important time for children to gain a sense of responsibility along with their growing independence.

What You Can Do…

- Talk with your child about puberty.
- Involve your child in household tasks.
- Be affectionate and honest with your child.
- Encourage your child to join school and community groups.
- Help your child develop his/her own sense of right and wrong.

Early Adolescence (12-14 years old)

This time consists of many physical, mental, emotional, and social changes. Hormones change as puberty begins. Your child might be worried about these changes and how others see him. Your child might experience moodiness and show less affection toward parents. Some teens may feel sad or depressed or develop eating problems.

What You Can Do...

- Be direct and honest with your teen about sensitive subjects like alcohol, drugs, smoking, and sex.
- Encourage your teen to exercise.
- Have meals as a family.
- Show an interest in your teenager's school life.
- Respect your teenager's opinions, thoughts and feelings.

Middle Adolescence (15-17 years old)

By this time, most girls will be physically mature and boys might still be maturing. Your child starts feeling as an adult and expects others to treat him in the same manner. This time period is very vital in regard to parental relationships as during this phase of development, your teen is developing his unique personality and opinions. Many teens start their social life as they prepare for more independence and bear responsibility. They often have increased interest in the opposite sex, often have conflicts with parents, and show deeper capacity for more intimate relationships. At this age some develop relationships which will lead into confrontations with parents. Often parents tend to disagree and look awkwardly at these relationships disregarding the feelings of the child.

What You Can Do...

- Talk with your teen about their concerns and pay attention to changes in behaviour.
- Show affection and compliment and appreciate him or her.
- Respect your teen's need for privacy. Rather than questioning their lives let him or her come out with the concerns of their life.
- Encourage your teen to get enough sleep and exercise.
- Help your teen plan ahead as to what to do in difficult situations when someone follows them or in uncomfortable situations they may face in public transport, when pressured to smoke or have liquor.

Parenting is a challenge, and parents may face many problems that will lead to the mental health mal development of a child. Such problems include:

➢ Busy lifestyles leading to lack of time and commitment to the family

➢ Parental work priorities such as duty shifts and financial matters.

➢ Lack of knowledge and skills in parenting especially understanding the children.

➢ Lack of support from family, relatives including grandparents.

- ➢ Family conflicts that lead to domestic violence - According research, people who have been abused or been victims of domestic violence have higher rates of mental health problems.
- ➢ Divorce and separation of parents.
- ➢ Households in which alcohol and drug misuse is common.
- ➢ The impact of social media and internet on parents and children - especially on early adolescent children who are developing their world views.
- ➢ School and education related problems.
- ➢ Sickness (physical or mental) of family members including children, parents or even grandparents.
- ➢ Prevalence of family drug taking or at-risk family behaviours (e.g., physical, mental or sexual abuse; illegal or antisocial activities).
- ➢ School, educational and recreational expenses, time and commitment priorities and so on.

Challenges with Puberty

Puberty generally sees the result of hormones being produced in massive amounts to meet changes in the body and also the brain. The prefrontal cortex of the brain which controls adult emotional, problem-solving and decision-making and many other cognitive functions, has not yet developed. Some children may have a marked interest in the opposite sex or rarely for some in the same sex (gay or lesbian) or both (bisexuality) or none at all. This is all a normal part of growing up, but can also be a time of great emotional and social confusion for the child. Views about body image and shape vary markedly in society, but can be a trying time for a teenager. For a girl, the size of her breasts and bra size, the shape of her hips and thighs and the onset of menstruation may be earth shatteringly important. For a boy, the onset of pubic hair, the desire for muscular growth and strength and facial hair may also be important in the transition to manhood. Males may be confused about how to impress a girl or what to say to girls. Females may feel unsure or insecure about the intentions of boys or even how to attract boys and try intimate relationships.

Both girls and boys alike may despair with having pimples or not having the ‘right shaped nose or legs or hair colour’ and be fearful of never having any friends or being liked by a dominant peer group. What may seem to be insignificant issues or problems in the view of parents or adults may be major problems or issues for teenagers.

The parent needs to show interest, to be actively involved with and to learn about their child and their new world rather than combat it or ignore it. The parent needs to know when to allow independence and when to intervene and this is not always an easy thing to do. Being a positive role model as a parent is perceived by some writers as important for a child’s development.

Health and learning related problems/situations may include:

- ADD (Attention Deficit Disorder) or ADHD (Attention Deficit Hyperactivity Disorder).
- Anxiety, distress, phobias and obsessions and even anxiety disorders.
- Eating disorders such as Anorexia Nervosa or Bulimia or alternatively poor diet leading to obesity. Often eating disorders are gender related body image issues and a desperation to have a sense of control over one's life and to avoid rejection by peers or to relieve boredom, anxiety or depression by not eating properly, purging after an eating binge, over eating nutritionally poor quality food, or body building to excess with or without chemicals/drugs.
- Bullying and abuse.
- Grief and loss (e.g., death of loved ones or favourite pets, loss of childhood and innocence, grief or apprehension regarding changed body image).
- Poor academic performances.
- Aggressive physical or acting out behaviour from boys.
- Depression with or without suicidal or self-harming thoughts and actions.
- Lack of sexual knowledge leading to risky or unsafe sexual behaviours and practices.

Each one of these problems/situations can cause grief, fear or despair for the child as well as for the parent. Situations may be exhibited as a means of independence.

The parent(s) in the face of what may seem to be some alien that has taken over their son or daughter's body and mind may feel a desperate need to overly control their son or daughter. Reaction against authority may be expressed in episodes of rebellion by the adolescent or feelings of alienation, hopelessness and a desire to self harm or to withdraw with an eating disorder. On the other extreme, the parent(s) may be the opposite and not care particularly where their son or daughter is or what they are doing and that can be just as problematic in setting their child up for failure (e.g., get into trouble with authorities, have an unwanted pregnancy, become drug dependent, or contract a sexually transmitted disease) in the community, with their studies or neglect of their current and future welfare or safety.

It is important to remember that the building of a positive child-parent relationship during adolescence is crucial. Regardless of the way that the child and parent respond to change, this will be long lasting, especially for the child's development into adulthood. The strong desire for being independent and all grown up must also be tempered by the child's need for some stability, comfort, love, guidance and understanding.

There are various mental health promoting factors (based on evidence) that are relevant to adolescent kids and to parents alike to reflect upon. They include:

Individual qualities

- Self-esteem
- Effective social interaction
- Good communication skills
- A sense of humor
- Religious activities
- The capacity to reflect on one's behaviour

Family qualities

- Family compassion, warmth
- Good parent-child relationship
- Affection
- Appropriate discipline within and outside the family
- Family support for education

Environment

- Creating effective social networks within the community
- Good housing environment; eg: cleanliness
- Sport and leisure activities
- Good schools with disciplined environment and with strong academic and non-academic opportunities

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Center for Disease Control and Prevention. *Positive Parenting Tips: Childhood & Adolescence* http://www.cdc.gov/parents/

Module 3:
Managing Depression; Rehabilitation and Burnout Prevention

Nursing Care in Depression

The WHO has estimated that one in four persons would develop depression by the year 2050. In the same year, 25% of the world population would be people over 65 years. Every health care worker, therefore, is expected to hold sufficient knowledge and skills in these areas.

Objectives:

At the end of the training, the participants should possess:

1. Knowledge about depression as a common mental health problem, and its clinical manifestations.
2. Knowledge and skills to identify depression, give basic care to patients with depression, identify risks and provide nursing care in recovery/rehabilitation for clients with depression.

Curriculum:

1. General knowledge about depression.
2. Symptoms and types of depression.
3. Goals for nursing a person experiencing depression.
4. Risks associated with depression; early identification and remedial actions.
5. Knowing basic management principles in depression.
6. Role of a nurse during follow up of a patient with depression.

Two Practical Sessions

Role play 1:
A patient presents with a hallucinating voice saying that he is useless and worthless. He gives a history of recent loss in his own business and is unable to attend day to day duties currently. His wife brings him to the OPD and the mental health nurse is called to assess the patient.

Role play 2:
A mother (a participant) notices her son (a participant) is not interested in talking to family members. The mother wants to know what is going on with the son.

Psychosocial Rehabilitation

Psychosocial Rehabilitation (PSR) is an ongoing process, which consists of intermediate objectives that are interrelated to each other and work towards the ultimate goal of recovery. Although this ultimate goal of 'recovery' may not always be possible, the objectives of psychosocial rehabilitation focus more on promoting independent living skills and vocational cognitive and occupational rehabilitation, aiding the consumer to live beyond the limitations of their disabilities to a meaningful quality of life. There are a number of strategies used to reach these objectives and goals in PSR that originate from different theoretical frameworks.

This session will focus on the objectives and goals of PSR and the different methodologies used to reach them. We will also highlight the professional and ethical principles that must be followed in applying such strategies.

Session Outline

1. What is PSR and what are its objectives?
2. Who does psychosocial rehabilitation?
3. What are the components of psychosocial rehabilitation?
4. Different strategies of providing PSR, highlighting the importance of each.

Discussion of the importance of applying knowledge and skill competencies in accordance with professional practices and ethics

At the end of this session the participants should have a:

1. A basic knowledge about PSR and about the different components of a psychosocial rehabilitation programme.
2. A knowledge about the principles and basis of the different strategies applied in PSR.
3. Awareness of the different strategies used in PSR.
4. Awareness of ethical principles in providing PSR.

Stress Management and Burnout Prevention

Stress, up to a certain extent, makes people to perform. When the level of stress is exceedingly high, it brings about devastating effects on health, both physical and mental. Stress is a subjective experience and its perception varies from individual to individual. Burnout may result from stress or lack of knowledge/understanding of one's duty or role. Having a knowledge of stress is of paramount importance to mental health workers since it exerts unwanted effects on work output and acts as the precipitant for development and relapse of mental illnesses.

Objectives:

At the end of the training, the participants should have developed;

1. Knowledge about stress, burnout and its outcomes.
2. Knowledge and skills to evaluate self and act accordingly.

Curriculum:

1. Understanding what is stress, eustress, distress, and burnt out.
2. Knowing type A and B behaviours.
3. Knowing how to do a self-assessment of stress.
4. Understanding serious outcomes of stress.
5. Understanding the relationship between mental illnesses and stress.
6. Acquiring knowledge and skills to counteract against stress.
7. Understanding the importance of holiday/vacation, off times, mindfulness, leisure activities, and assertiveness
8. 2 practical sessions (to identify a stressed person and underlying cause, to be assertive against forced overtime work)

<u>Role play 1:</u>

A patient (a participant) is ready to be discharged from a ward. He/she sought frequent admissions to the ward. A nursing staff (a participant) finds the patient's mother (a participant) yells at him/her for not getting ready quickly. Discuss the issue (relevance, how to deal with it).

<u>Role play 2:</u>

A nursing officer (a participant) in charge has assigned more duties to a young nursing nurse (a participant). The mother (nurse) finds less time to feed her baby. The nurse in charge should describe how to evaluate the effects of her decision. The nursing nurse should describe how to evaluate the effects of the additional duties place upon her. Participants should describe how to deal with the issue.

Study Material 3

Depression

What is Depression?

Depression is a common mental health disorder, affecting one in five persons at any time over anyone's lifetime. However, for a person to be clinically diagnosed with a depressive disorder, his or her depressive symptoms must be much more marked, intense and must have been present for at least two weeks. Depression is commonly accompanied by feelings of anxiety or agitation with a variety of many other symptoms.

Symptoms and Types of Depression

Depression is often categorised as a mood disorder in psychiatry according to the severity of symptoms. The primary subtypes are mild, moderate and severe depressive disorder.

Depression that begins or occurs during or after pregnancy is referred to as a type of perinatal mood disorder (which includes ante-natal and postnatal depression). Depression that occurs in conjunction with episodes of mania may be symptomatic of bipolar affective disorder.

Common symptoms of depression include:

- sleep disturbance
- appetite or weight changes
- dysphoria (a 'bad mood', irritability, or sadness)
- anhedonia (loss of interest in work, hobbies, sex, etc.)
- fatigue (often manifesting as difficulty completing tasks)
- agitation or retardation, especially in the elderly
- diminished concentration, difficulty with simple tasks, conversations etc.
- low self-esteem or feelings of guilt
- suicidal thoughts present in two-thirds of people experiencing depression.
- Children and adolescents may present with an irritable or anxious mood rather than being sad.

Causes, Onset and Course of Depression

People get depressed as a result of any one (or more) of a range of factors, including:

- physical stress
- chronic illness
- psycho social issues

- genetic predisposition
- continuous life stressors
- personality factors
- financial break downs etc.

Depression may have an acute or gradual onset and can be experienced any time over the course of a person's life. A large number of patients experience features of depression during chronic physical disease. Many of these people may be seriously disabled by their symptoms of depression, rather than the actual medical illness. Most of these even require referral to mental health services.

For example, research shows the effect of co-morbid depression on patients with asthma, as follows (Mancuso et al, 2000):

- 45%-55% of asthma patients were also found to be depressed.
- The depressed patients reported worse health-related quality of life.
- They had lower scores on many measures of functional capacity.

Other examples of illustrative research on the effects of co-morbid depression include myocardial infarction (Jones, 2000), diabetes (Anderson et al, 2001), stroke/cerebral vascular accident (House, 1999).

Difficulties in Diagnosis

Depression can be difficult to diagnose, especially in South Asian countries like Sri Lanka as people with depression often present complaining of physical problems, which may be initially difficult to establish as a psychiatric diagnosis.

Depressive disorders often coexist with, and may be secondary to, other mental disorders. Particularly high rates of depression are found in people with alcohol-related disorders, eating disorders, schizophrenia and somatoform disorders. Understanding which disorder is primary and which is secondary is often a difficult task.

Many of the people nurses care for, both young and old, are at risk of developing depression due to longstanding physical illness and disability. Further, depression can present as an early sign of dementia. It is important then for nurses to remain alert to this possibility of developing depression.

Role of a Mental Health Nurse in Caring for a Person with Depression

- Develop a therapeutic relationship with the person based on empathy and trust.
- Help the client to build up effective coping and problem solving skills in a self-empowering manner.

- Promote positive healthy behaviours, such as medication compliance and healthy lifestyle including healthy diet, exercise, cessation of smoking, limiting consumption of alcohol and other substances.
- Promote the person's engagement through their social relationships.
- Educate the patient about anti-depressive medication and the required time that is needed for a therapeutic response.
- Support and promote self-care activities for families and carers of the person with depression.

During a Review of a Person with Depression Always:

- Look for medication compliance and experience of its adverse effects.
- Assess whether the person's helplessness or hopelessness are indicators of suicidal thinking.
- Any suicidal plans or attempts (current or past).
- Encourage the person to talk about how he or she feels specially after starting medications, evaluate the response.
- Do not make or agree with any negative comments or behaviours by the patient.
- Show empathy and support. However, avoid being overly sympathetic, as the person may feel that you are being condescending.
- Avoid statements such as 'Things can't be that bad' and 'Everything will be okay', as the person might feel that you do not really understand his or her problems. This may make the person unwilling to share other feelings.
- Encourage the person to carry out self-care.
- Encourage the person to participate in purposeful activity and daily routine.
- Point out any improvements in the person's condition such as sleeping and eating patterns and encourage him/her. Teach him/her to look at the bright side of the things happening around him.
- Reinforce the person's strengths and positive attributes by encouraging the person to value his or her achievements, relationships and health.
- Monitor recovery, compliance with medication and general physical health.
- Provide family members and carers with information about the illness, encourage family members and carers to look after themselves and seek support if required.
- Be aware of your own feelings when nursing a person with depression.

Treatment for Depression

Counselling and Psychological Therapies

- Cognitive behaviour therapy (CBT)
- Interpersonal therapy
- Family therapy
- Psychodynamic psychotherapy
- Psychosocial strategies including education, counselling and support for the person and his or her family
- Stress management and compliance with medication.

Medication

- Selective serotonin uptake inhibitors (SSRIs), (for example, sertraline, fluvoxetine)
- Serotonin or noradrenalin reuptake inhibitors (SNRIs), (for example, venlafaxine)
- Atypical antidepressants (mirtazepine)
- Tricyclic (amitriptyline, imipramin)
- Monoamine oxidase inhibitors (phenelzine, tranylcypromine).

ECT

Electroconvulsive therapy (ECT), is a safe and highly effective treatment for the most severe forms of depression. The aim is to induce a highly modified seizure thought to positively influence levels of neurotransmitters, leading to improvement in mood or reduction of psychotic symptoms. ECT may be life-saving for those at high risk of suicide or who, because of the severity of their illness, have stopped eating and drinking and may die as a result.

Discharge Planning

Active follow-up includes assessing the patient's response to treatment, suicide risk assessment, patient information, education, and self-help techniques. Patients need to be seen regularly to assess whether their depression is improving. Action must be taken when they do not attend appointments.

Patient concordance with medication

For patients receiving antidepressant medication as part of their treatment, information, support and regular contact in the early stages are crucial. Lack of knowledge leads many patients to abandon drug therapy.

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What is Rehabilitation?

In Psychosocial rehabilitation, we talk about recovery, community integration and improved quality of life for persons who have been diagnosed with any mental health condition that impairs their ability to lead meaningful lives like other people in the community. It is a collective effort, person directed and individualised. It helps individuals to develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice.

Goals of Rehabilitation.

- Maximise continuity of care, adherence to treatment with the individuals' capacities.
- Reduce the stresses the patient is undergoing.
- Enable optimal economic and social participation.
- Avoidance of relapse and improve social interactions.

Psychosocial rehabilitation will help to reduce stigma and handicap and promote equity and opportunity to the mentally ill. It should involve all spheres, the organizational, legislative, professional, quality of care and quality of life assurance, family organisation and support.

What is Recovery?

Mental health recovery is a journey of healing and transformation to enable a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve maximum human potential. It can be defined as the improved ability to lead a fulfilled life that is not determined by illness or treatment. Recovery is about experiencing an improved quality of life and higher levels of functioning in spite of illness and does not require people to experience a reduction of symptoms or the need for medical or social care.

Recovery and Psychosocial Rehabilitation (Adapted from IAPSRS 1999)

1. Recovery is the ultimate goal of Psychosocial Rehabilitation (PSR). PSR Interventions must facilitate the process of recovery.
2. Psychosocial Rehabilitation practices help people re-establish roles in the community and their reintegration into community life.
3. Psychosocial Rehabilitation practices facilitate the development of personal support networks, enhanced quality of life for each person receiving services.
4. People receiving services have the right to direct their own affairs, including those that are related to their mental illness.

5. All people are to be treated with respect and dignity.
6. Culture and/or ethnicity play an important role in recovery as sources of strength and enrichment for the person and the services.
7. Psychosocial Rehabilitation interventions are built on the strengths of each person. And its services are to be coordinated, accessible, and available as long as needed.
8. 1All services are to be designed to address the unique needs of each individual, consistent with the individual's cultural values and norms.

Objectives of Psychosocial Rehabilitation

- Reducing symptomatology through appropriate pharmacotherapy, psychological treatments and psychosocial interventions.
- Reducing iatrogeny by diminishing and eliminating, whenever possible, the adverse physical and behavioural consequences of the above interventions, as well as - and in particular - of prolonged institutionalisation.
- Improving social competence by enhancing individuals' social skills, psychological coping and occupational functioning.
- Reducing discrimination and stigma.
- Family support to those families with a member who has a mental disorder.
- Social support by creating and maintaining a long term system of social support, covering at least basic needs related to housing, employment, social network and leisure.
- Client empowerment by enhancing consumer's and carer's autonomy, self-sufficiency and self-advocacy capabilities.

COMPONENTS OF RECOVERY

Strategies

At Individual Level

Pharmacological treatment

The correct use of psychotropic medication is often an essential component of PSR. Suitable medication is useful in the reduction of symptoms and in preventing relapses. Education on adverse effects of the medication is vital

Independent living skills and social skills training

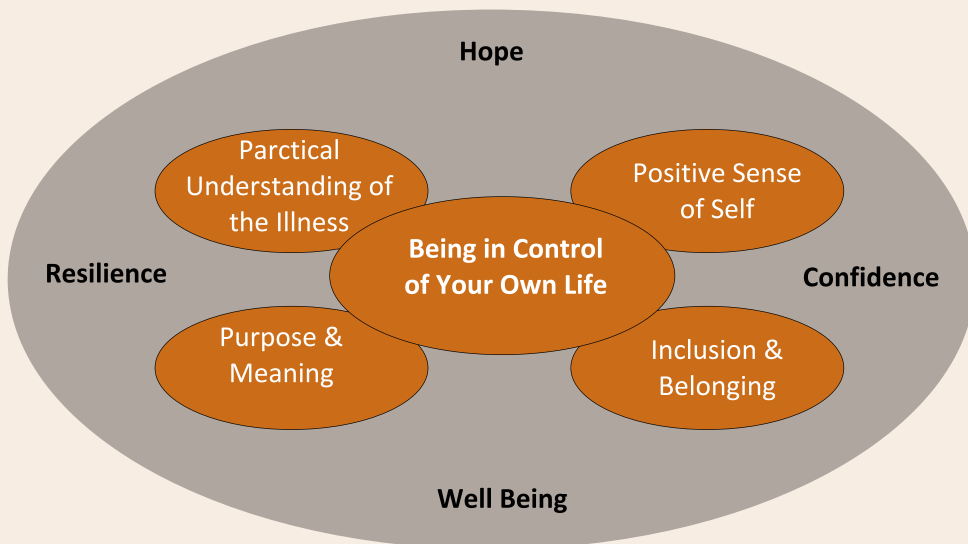
All the interventions related to basic daily living activities such as feeding, bathing, dressing, etc. Social skills are those skills that are needed in social and interpersonal interactions.

Training for both types of skills have to take place in real everyday life experiences, not in closed, unrealistic settings like in the ward. Social skills training is most useful when given as part of overall rehabilitation skills such as going shopping, attending a party etc.

Psychological support to patients and their families

Psychological support represents a vital role in psychosocial rehabilitation. Intensive and continuing psychological support to patients and to their families, including education, is widely accepted as a key component in psychosocial rehabilitation. Self-help groups for relatives of long-term patients have also been proved to be an effective strategy.

PERSONAL RESOURCE BASE



Work and employment

Working and having a job increases the client's satisfaction and self-esteem and breaks the cycle of poverty and dependence. In addition, work provides an opportunity to develop social interactions and interpersonal effective communication. Therefore, it is essential to set up vocational training activities. Having an independent income is a powerful tool in enhancing consumer empowerment.

Social support networks

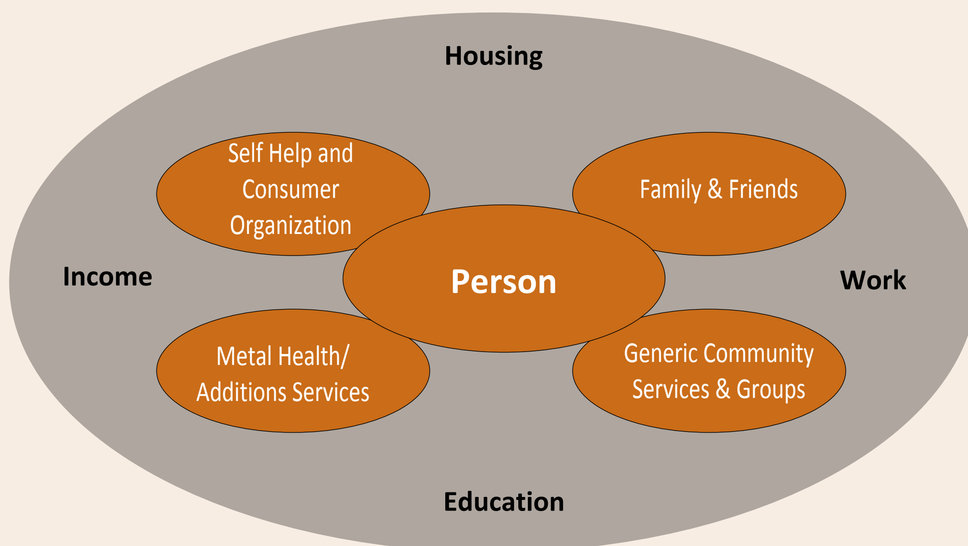
Social support networks are a set of human relationships that help in the exchange of emotional, physical, economical and intellectual influence. They work mostly by strengthening the individual's coping ability.

Leisure

Participation and enjoyment of leisure activities of one's choice is also very important in PSR. Access to appropriate leisure activities and freedom of choice needs to be facilitated.

At Societal Level

COMMUNITY RESOURCE BASE



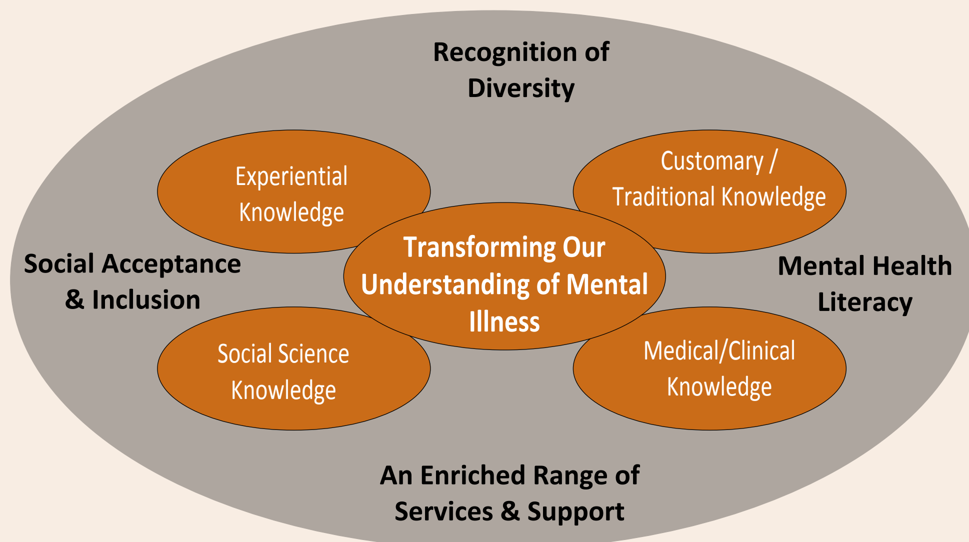
Client empowerment

Clients should actively participate in planning, delivering and evaluating PSR programmes. This empowerment is not only a realisation of the formal rights of patients but also helps the client to access community resources.

Improvement of public opinion and attitudes related to mental disorders

The stigma and discrimination related to mental health disorders are based on negative attitudes and wrong beliefs about mental disorders; such attitudes and beliefs are sometimes found even among fellow health workers. A lot of health promotional activities have to be arranged to correct these issues.

KNOWLEDGE RESOURCE BASE



"If the foundation for a people's mental health lies in the existence of humanizing relationships, of collective ties within which and through which the personal humanity of each individual is acknowledged and in which no one's reality is denied, then, the building of a better and more just society, is not only an economic and political problem; it is also essentially a mental health problem".

\- Nacho Martin-Baro, Social Psychologist

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Stress Management and Burnout Prevention

Stress and the Mental Health Nurse

Working in the health sector is stressful job. And being a part of the mental health team makes it more complicated. Consciously or not, the hospital mental health team undergoes immense stress. Adoptive and coping mechanisms for stress must be well developed and practiced, to maintain good mental wellbeing by the mental health staff. Being able to identify stress and to develop ways to manage it is essential so as to maintain your health, achieve job satisfaction and to engage in daily routine activities with balanced mental health.

Mental health nurses are particularly vulnerable to stress mainly due to a lack of staff leading into long shift duties, problems in community support of the patients and poor drug compliance that causes recurrent relapses of illness thereby increasing hospital readmission that creates busy wards. Additionally, the lack of facilities, including infrastructure for staff welfare, stigma within the health staff and client pressures including the risk of violence are additional factors of stress. Research shows that the prevalence of burnout amongst mental health nurses has reached as high as 59.2% in some settings. Therefore, the need for intervention in prevention of burnout is very important.

What is this Stress?

It is a physical and emotional response to excessive pressures or other types of demands placed upon one by himself or by the social environment around him/her. Stress makes a person feel unable to cope with these pressures/demands. Stress is often associated with stress with a negative event, but this is not always the case. It is also associated with positive changes in life, such as a new job or getting married. The intensity of physical or emotional reactions caused by stress varies from one person to another. An event that creates an excessive amount of stress in one person may only create a minimal amount of stress in another person. It depends on how we address the situation and that determines whether stress will impact our health and well-being.

There are two instinctive responses to stress that occur:

- **The Fight or Flight Response**

  This is a short term response of the body to a threat. It is characterised by an increase in heart rate or blood pressure which gives more strength to the muscles. One becomes excitable, anxious or irritable as emotional responses to stress. In a practical set up such response reduces our ability to work effectively with others, impacts the ability to make good decisions, and increases the risk of accidents and adverse events in the ward.

- **The Adaptation Syndrome**
  It is a response to longer term exposure to causes of stress, which is also known as burnout. In our day to day life, most of our daily stressors occur without obvious threat to survival; such as work overload, conflicting priorities, children's matters including education, financial issues, conflicts with co-staff members, an unpleasant environment at home, etc. These factors reduce our performance by distracting us and making it difficult to focus our attention on the task at hand. They can also cause unhappiness and dissatisfaction in life.

Due to such long-term stress, our health can be affected. The more severe you perceive the stress to be, the more your body will respond. Health issues caused by stress can include: a weak immune system (which leads to colds and the flu), intensifying symptoms in diseases that have an autoimmune component, headaches, ulcers, and many other serious health problems.

The Impact of Stress on Work

Stress and burnout can affect our duty in the following ways:

- Job performance will reduce since one will become easily distracted.
- Interaction with co-staff members will be negatively affected leading to frequent confrontations.
- Anxiety and negative emotions will dominate in the mind disturbing your usual nature of thinking.
- Decision-making and creative ideas may be impaired because the mind is focusing mainly on the stress.
- One may need to take frequent leave due to an insufficient ability in coping with the stress.

Speak Out Your Concerns

Good communication is useful to avoid provocation to stressful events. Communicating your needs will help to reduce stress. Having a bad day and yelling at the health service assistant or your co- nurse isn't good communication that will reduce stress. Always remember to be respectful towards your assistant and to be aware of your feelings and its expressions. If you are having a bad day, tell your assistant or co-nurse about it. If you convey to your co-nurse or the health services assistant that you are having a bad day it will effectively work to reduce your stress. He or she might share the burden with you and ease your work load. Specially keep in mind that you do not make crucial decisions or react spontaneously when you are under stress.

Burnout Prevention

It is a collection of symptoms that occur mainly as physical fatigue due to overwork. Stress and emotional exhaustion are part of it, but the main cause of these reactions is burnout.

Burnout Symptoms

Stress is a natural reaction and can be a part of everyone's life. But when stress becomes more serious, burnout begins to occur. A clear sign is when a person loses interest and motivation in things they normally enjoy. It usually occurs over a period of time, and can affect a person both physically and mentally. Some other symptoms are:

- A feeling of lack of control over commitments
- Wrong beliefs that one is achieving less in life.
- Negative thinking
- Loss of life's purpose and lack of energy in daily activities
- Increasing detachment from social relationships

It is very important to have a clear idea about preventing burnout. If you are under stress or are in a stage of burnout, this may carry over into your work. If you begin to notice signs of burnout within yourself, talk to someone about it.

At the same time, it is important to seek support when required. If problems occur, address the issue right away, try to rectify it. This will help to reduce your stress level. Keep in mind that any delay in finding answers to certain problem can make things worse over time.

If you feel you are burning out, try these:

- Re-evaluate your goals and prioritise them.
- Identify your abilities and decide whether the goals are achievable. If not reconsider the goals.
- Reduce excessive commitments if you are overwhelmed.
- Seek help when it is needed.
- Explore other areas in your life that are generating stress, except duty such as family, and try to solve those problems to reduce further stress.
- Have a healthy lifestyle.
- Get adequate sleep and rest.
- Eat a healthy, balanced diet.
- Have adequate exercise.
- Limit your alcohol intake.
- Develop alternative activities such as a relaxing hobby that will take your mind off problems.
- Have some time to engage in religious activities.
- Acknowledge your own humanity: remember that you have a right to pleasure and a right to relaxation.

Identify that you are stressed without delay

It is important for you to recognise stress before it turns into burnout. Because the latter can impact on your ability to work with others. So, awareness is essential.

How to Reduce Stress

Coping with Stress

- You should spend time doing things that make you happy or help you relax.
- Make a list of activities that bring you joy and relaxation, and allocate time in your daily routine of the day.
- Practice mindfulness or relaxing meditation that suits you.
- Listen to a relaxing music
- Creatively think how you would like the stressful situation to change. This may help you to come up with ideas that can help to reduce the stress in the situation.
- Take a break - go for a walk, have a cup of tea or get away from the situation for a few minutes and come back in a calmer mind.
- Ask yourself if the stress you are experiencing is really needed. If not, let it go.
- Deal with the stress directly when possible. Talk to a trusted person about it, especially if the stress you are experiencing involves something they may have said or done.
- Talk about the problem with a friend, family member or professional, or write it out in a letter and throw it away letting the stress disappear.

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