COURSE GUIDE

NSC 314
MENTAL HEALTH AND PSYCHIATRIC NURSING I

Course Team Ejidokun Adeolu, Afolabi A.A.
Oluwaseyi Olabisi (Course Developers/Writers)
Dr. O.O. Irinoye (Course Editor)
Mr. Adeolu Ejidokun (Course Coordinator) - NOUN

NATIONAL OPEN UNIVERSITY OF NIGERIA

National Open University of Nigeria
Headquarters
University Village
Plot 91, Cadastral Zone
Nnamdi Azikiwe Expressway
Jabi, Abuja

Lagos Office
14/16 Ahmadu Bello Way
Victoria Island, Lagos

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

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INTRODUCTION

There is no Health without "MENTAL HEALTH" but many people seldom talk and some only pay little attention to doing things to promote their mental health. Many people who have mental health challenges may not even know that they have such not to talk of seeking help!

Hello, welcome to this course. We are happy to have you doing NSC 314 – Mental Health and Psychiatric Nursing I. You would have done some lectures in Mental Health and Psychiatric Nursing when you were in the basic school of nursing. You are going to do a little more and have opportunities to have practical sessions to give you more facts and experinces in Mental Health and Psychiatric Nursing. Intrestingly, we all learn a lot from been able to look at our own lives too. As nurses you must be able to manage your mental health to be able to provide mental health care. You must have desirable knowledge about how the link between the body and the mind, how the mind functions before you can determine if and when something goes wrong, what goes wrong and what you can do within your professional responsibility to help clients achieve, maintain, sustain, retain and adjust to permant change in their lives.

This course, along with the others must be learnt with your professional roles and duties in mind at all times for you to also see how you can apply your new learning to improve your current practice.

This Course Guide breifly gives you information about this course and how you can succesfully go through the course. Please study it carefully.

COURSE OVERVIEW/DESCRIPTION

Mental health and Psychiatric Nursing is the specialty of nursing that cares for people of all ages with mental illness, mental distress or disorders that involve disturbances in thinking, emotion, and/or behavior. Small disturbances in these aspects of life are common, but when such disturbances distress the person greatly and/or interfere with daily life.
Nurses in this area receive more training in psychological therapies, building a therapeutic alliance, dealing with challenging behavior, and the administration of psychiatric medication.

The course is presented in Modules with small units. Each unit is presented to follow the same pattern that guides your learning. Each module and unit have the learning objectives that helps you track what to learn and what you should be able to do after completion. Small units of contents will be

presented every week with guidelines of what you should do to enhance knowledge retention as had been laid out in the course materials.

COURSE OBJECTIVES

At the completion of this course, you should be able to:

- Apply the concepts in mental health and psychiatric nursing correctly.
- Describe the current issues and trends of care in mental health and psychiatric nursing.
- Discuss the different coping mechanisms the clients use in the management of stress and anxiety.
- Discuss the signs and symptoms of psychiatric disorders.
- Discuss personality and common personality disorders.

COURSE IMPLEMENTATION
DOING THE COURSE

The course will be delivered adopting the blended learning mode. You will have hard and soft copies of course materials, you will also have online interactive sessions, face-to-face sessions with instructors and preceptors in clinical sites and very limited campus face-to-face activities. The interactive online activities will be available to you on the course link on the Website of NOUN. There are activities and assignments online for every unit every week. It is important that you visit the course sites weekly and do all assignments to meet deadlines and to contribute to the topical issues that would be raised for everyone's contribution.

You will be expected to read every module along with all assigned readings to prepare you to have meaningful contributions to all sessions and to complete all activities. There will be opportunities for group work, case analysis and presentations. In this course, you will need to report some of your real life experiences working with people at the community level for health promotion activities. We would also learn how to do academic critiquing of each other's work, individuals and groups, in professional manners demonstrating high level of respect and efforts to help each other grow. We would demand that you recognize cultural diversity and respect cultural differences and treat your classmates, facilitators, preceptors and community members with respect and dignity.

COURSE REQUIREMENTS AND EXPECTATIONS OF YOU

Attendance of 95% of all interactive sessions, submission of all assignments to meet deadlines; participation in all CMA, attendance of all laboratory sessions with evidence as provided in the log book, submission of reports from all laboratory practical sessions and attendance of the final course examination. You are also expected to:

1. Be versatile in basic computer skills.
2. Participate in all laboratory practical up to 90% of the time.
3. Submit personal reports from laboratory practical sessions on schedule.
4. Log in to the class online discussion board at least once a week and contribute to ongoing discussions.
5. Contribute actively to group seminar presentations.

EQUIPMENT AND SOFTWARE NEEDED TO ACCESS COURSE

You will be expected to have the following tools:

1. A computer (laptop or desktop or a tablet)
2. Internet access, preferably broadband rather than dial-up access.
3. MS Office software – Word PROCESSOR, Powerpoint, Spreadsheet.
4. Browser – Preferably Internet Explorer, Moxilla Firefox.
5. Adobe Acrobat Reader.

NUMBER AND PLACES OF MEETING ONLINE, FACE-TO-FACE, LABORATORY PRACTICALS

The details of these will be provided to you at the time of commencement of this course.

DISCUSSION FORUM

There will be an online discussion forum and topics for discussion will be available for your contributions. It is mandatory that you participate in every discussion every week. You participation link you, your face, your ideas and views to that of every member of the class and earns you some mark.

COURSE EVALUATION

There are two forms of evaluation of the progress you are making in this course. The first are the series of activities, assignments and end of unit, computer or tutor marked assignments, and laboratory practical sessions and report that constitute the continuous assessment that all carry 30% of the total mark. The second is a written examination with multiple choice, short answers and essay questions that take 70% of the total mark that you will do on completion of the course.

Students' evaluation: The students will be assessed and evaluated based on the following criteria.

- **In-Course Examination:**
  In line with the university's regulation, in-course examination will come up in the middle of the semester These would come in form of Computer Marked Assignment. This will be in addition to 1compulsory Tutor Marked Assignment (TMA's) and three Computer marked Assignment that comes after every module…..
- **Laboratory practical:** Attendance, record of participation and other assignments will be graded and added to the other scores form other forms of examinations.
- **Final Examination:** The final written examination will come up at the end of the semester comprising essay and objective questions covering all the contents covered in the course. The final examination will amount to 60% of the total grade for the course.

Learner-Facilitator evaluation of the course
This will be done through group review, written assessment of learning (theory and laboratory practical) by you and the facilitators.

GRADING CRITERIA

Grades will be based on the following Percentages		
Tutor Marked Individual Assignments		10%
Computer marked Assignment	10%	
Group assignment	5%	40%
Discussion Topic participation	5%	
Laboratory practical	10%	
End of Course examination	60%	

GRADING SCALE

A = 70-100
B = 60 - 69
C= 50 - 59
F = < 49

SCHEDULE OF ASSIGNMENTS WITH DATES

Every Unit has activity that must be done by you as spelt out in your course materials. In addition to this, specific assignment will also be provided for each module by the facilitator.

SPECIFIC READING ASSIGNMENTS

To be provided by each module.

REFERENCE TEXTBOOKS

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

Morrison-Valfre, M. (2005). Foundations of Mental Health Care. Missouri: Mosby Inc.

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

Mary C. Townsend (2009). *Psychiatric Mental Health Nursing: Concept of Care in Evidence Based Practice*. Philadelphia: F.A. Davis.

COURSE MATERIAL

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Mental Health and Psychiatric Nursing I

Module 1 Introduction to Mental Health and Psychiatric Nursing

MAIN COURSE

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MODULE 1 INTRODUCTION TO MENTAL HEALTH AND PSYCHIATRIC NURSING

UNIT 1 CONCEPTS IN MENTAL HEALTH AND PSYCHIATRY

CONTENTS

1.0 INTRODUCTION

"Mr James Audu Ibekwe is a friendly, jovial and happy person who has very amiable relationships with family members at home and co-workers in his place of work. He makes people feel good and corrects everyone in ways to enhance their self worth. He is unlike Mr Dauda Ikechukwu Rehoboam who cannot see anything good in anyone, selfish, arrogant, ever moody, always shouting people down, ever suspicious of others and so difficult to live and work with". Do you know people line these two people? Who would you say is healthy of the two? I am sure you are familiar with the World Health Organization's definition of Health – A state of physical, mental, social (and spiritual) well being and not merely the absence of disease.

Many people, including you and I, throw around terms, including mental health, in everyday use without really understanding the meanings! So

what is mental health? Mental health is a broad term. Some use it as a simple synonym to describe our brain's health. Others use it more broadly to include our psychological state. Still others will add emotions into the definition. I believe a good definition includes all of the above. Mental health describes our social, emotional, and psychological states, all wrapped up into one. You will learn more in this unit about the concept of health and mental health, as well as psychiatry and mental health and psychiatric nursing.

Figure 1.1 Mental Health Expression
http://www.google.com.ng

Fig. 1.2; Perception of mental Health
http://www.markfreeman.ca/wp-

There is often a lot of confusion about what we mean when we talk about mental health. Many people immediately start thinking about mental health problems or mental illness – but this is only one part of the picture.
Everyone has 'mental health' and this can be thought of in terms of:

- how we feel about ourselves and the people around us
- our ability to make and keep friends and relationships
- our ability to learn from others and to develop psychologically and emotionally.

Being mentally healthy is also about having the strength to overcome the difficulties and challenges we can all face at times in our lives, to have confidence and self-esteem, to be able to take decisions and to believe in ourselves.

In this module you will learn the basic concepts in mental health and psychiatry, and you will be able to identify those factors that promote mental health.

2.0 OBJECTIVES

At the end of this module, you will be able to:

- discuss concepts in mental health and psychiatry
- determine a mentally healthy person
- predict mental health direction of an individual
- explain the concept of health
- define mental health
- describe the concept of mental health and psychiatric nursing
- list various special fields of psychiatry
- identify the misconceptions of psychiatry.

3.0 MAIN CONTENTS

3.1 Concept of Health

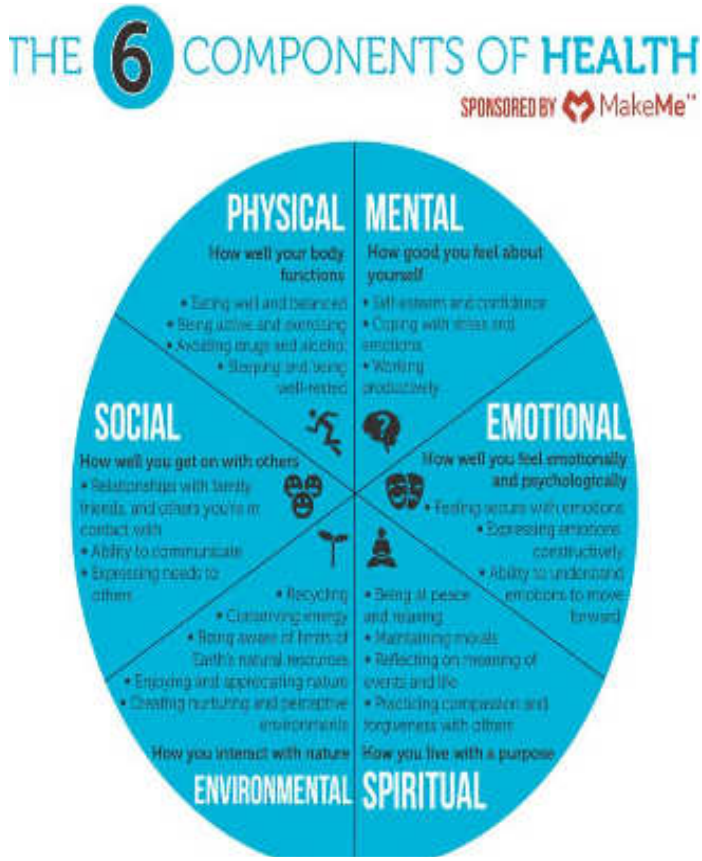

Fig. 1.3 Components of Health
http://www.pinterest.com/pin/

"Health" is a word that has a common use. It features prominently in consumer goods advertisement, especially with those dealing with food, drugs and cosmetics. It also features in our everyday conversations, good wishes and greetings. It is expressed either implicitly or explicitly and has become the concern of every individual, family, community and the government. It is a term that was not defined in any precise way until when the World Health Organisation put forth its definition which has now been accepted as a standard definition among health practitioners. The Organization defined health as "a state of complete physical, mental and social well-being and not merely absence of disease or infirmity". There are two parts to this definition. The first part sees health as "a state of complete physical, mental and social well-being" and the second part views health as not necessarily the "mere absence of disease or infirmity".

This first part of the definition clearly points out the fact that health has at least three dimensions or components – mental, physical and social components. The second part confirms the above view by clearly pointing out that the absence of disease and infirmity does not mean that health necessarily exists. In other words, health cannot be determined by observing or evaluating the physical or physiological status of a person.

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

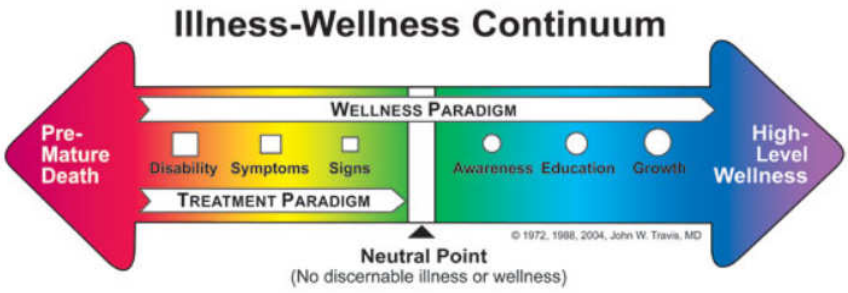

Fig 1.4: Health – Illness Continuum

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

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

An analysis of this definition shows that there are four components:

i. as the unity of the individual,
ii. as a quality of life,
iii. as an achievement of personally satisfying life, and
iv. as an achievement of socially useful life.

2. Health is that state or quality of life which enables an individual to face up to crisis, carry out his daily responsibilities efficiently and relate to other persons effectively.
   The above definition gives health the pride of place. By implication, only the person who is in health can function in any meaningful way and the functional level is dependent on the level of health such a person is enjoining.
3. Health is that quality which enables one to "live most and serve best" (Williams, 1933).

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

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

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

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

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

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

Since health fluctuates on the health continuum, it is therefore a quality of life which results from one’s total functioning within one’s physical, biological and social environment. Effective living is also a result of a person’s functioning in a variety of life’s situations which include his physical, mental, social and spiritual experiences. What you do – such as your work, leisure activities, social engagements, food habits, your failures, your frustrations, etc. – all combine to determine your quality of life.

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

Health is a phenomenon which transcends the individual. Although most individuals are concerned with their personal health, there is more to it as it is also concerned with the home as well as the community to which the individual belongs. It is therefore incumbent on everyone who has achieved good health to seek for the welfare of members of his family and

community. A person who is in the peak of health but surrounded by squalor and filthy environment and hunger cannot be considered healthy. Good health requires an achievement of a socially useful life, as well as maintaining good physical, emotional and spiritual wellbeing

3.2 Concept of Mental Health
What Is Mental Health?

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

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

Fig. 1.5: Mental Health
Source: http://www.corrections.com/news/article/28921-are-we-all-on-the-treatment-team-.

Definitions of Mental Health

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

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

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

Johoda (1958) sees a mentally healthy person as one who:

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

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

These include:

1. Physiological needs (food, sleep, sex etc.).
2. Safety and security needs.

3. Love (or belongingness) need.
4. Self-esteem need.
5. Self-actualization need.

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

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

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

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

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

1. Mental health requires emotional stability and maturity of character; as well as the strength to withstand strains and stresses in today's society without undue physical and psychological discomfort.
2. Mental health implies the ability to judge reality accurately and to see things in their true perspective and in terms of their long term rather than short-term values.
3. Mental health means the ability to love and to be loved as well as to be able to sustain affectionate relationship with others. This demands the presence of affectionate conscience, realistic, independent and at the same time a practical code by which to live.
4. Mental health demands satisfaction of needs such as basic physiological need, security need, self-esteem and self-

actualisation need in such a way that neither self nor other persons are hurt.

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

3.3 What is Psychiatry?

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

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

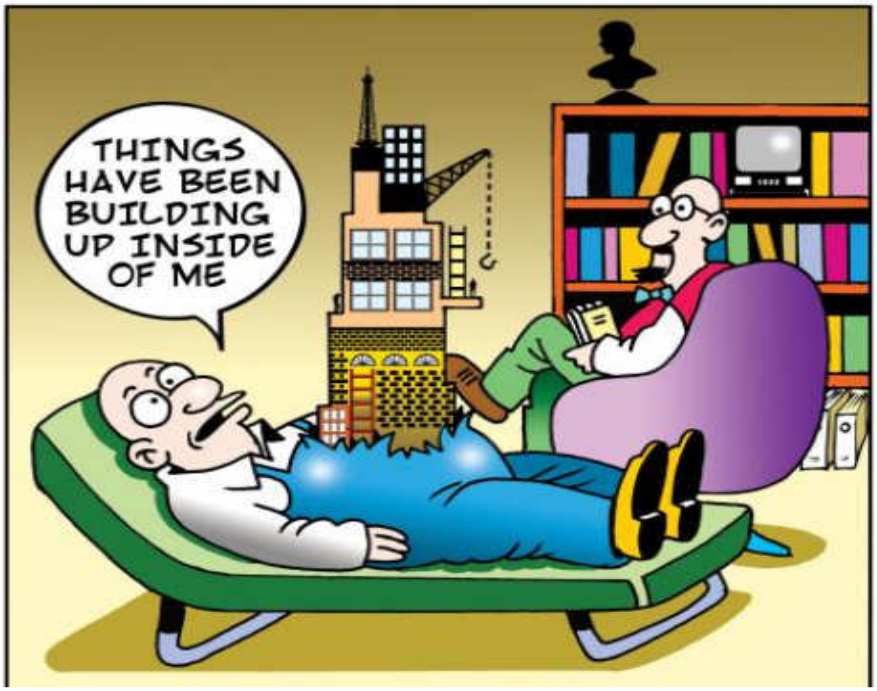

Fig. 1.6 Psychiatric symptom Source; http://lol-rofl.com/psychiatry-cartoons/

Special Fields of Psychiatry

(a) Child Psychiatry: Child psychiatry deals with the diagnosis and management of psychiatric problems that have their onset in childhood. Child psychiatry is primarily concerned with the study and treatment of behavioral disorders and emotional problems that affect children. Emotional maladjustments of children frequently are characterized by anxiety reactions. They may include habit disorders—such as nail-biting, thumb-sucking, bed-wetting, and temper tantrums—and conduct disorders—such as extreme aggressiveness, lying, stealing, destructiveness, fighting, fire setting, cruelty, and running away from home.

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

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

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

is apt to be repressed and is actually failing to deal with the problems of this phase of life.

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

(f) Transcultural Psychiatry: The study of mental disorder against diverse cultural backgrounds – is an extension of cultural psychiatry. It is both a theoretical and a practical discipline in which the psychiatrist and the patient have different cultural origins. Psychiatry's horizons are ever widening – from individuals to families, industries, communities, cultures, nations and the world knowledge of the one illuminates the many; problems and customs of the many impinge on the one.

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

3.4 What is Mental Health and Psychiatric Nursing?

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

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

The goal of Mental Health and Psychiatric Nursing care is to encourage the patient to face reality and resume independent action as soon as possible. The Mental Health and Psychiatric Nurse assists in working towards this goal by: his/her humanistic and understanding contacts with patients in his/her day-to-day activities, being a member of the therapeutic team in establishing a therapeutic milieu, and formally conducting psychotherapy with some patients.

The attainment of these goal results in the establishment of patterns of behaviour that is more satisfactory and satisfying to others. Therefore, helping persons to accept themselves to improve their relationships with other people and to function independently are the most fundamental goal in Mental Health and Psychiatric Nursing. Mental Health and Psychiatric Nursing provides opportunities for patients to change their maladaptive behaviour.

A Mental Health and Psychiatric Nurse is a member of the "Therapeutic team" which includes the psychologist, social worker, occupational therapist, and auxiliary workers. Mental Health and Psychiatric Nurse assists in formulating and implementing a broad plan of care for each patient to meet his total needs. This plan is developed after some contact with the patient so that all team members can share their observations and outline some of the patient's most obvious needs. **Psychiatric Team**

Fig. 1.7: Mental Health and Psychiatry as a team work
Source: http://www.mentalhealthy.co.uk/news/716-care-quality-

commission-survey-of-mental-health-service-users.html
Whether a psychiatric patient is admitted into the hospital or treated as an out-patient, the modern method of care in both instances is mainly "a team approach". Thus:

(i) One or more Psychiatrists (Doctors) with a Consultant acting as a team leader
(ii) Ward or Unit Nursing Sister/Superintendent
(iii) Mental Health and Psychiatric Staff Nurses
(iv) Occupational Therapist
(v) Psychiatric Social Worker
(vi) Psychologist. are involved in the management of and care of mentally ill.

3.5 Misconceptions of Psychiatry

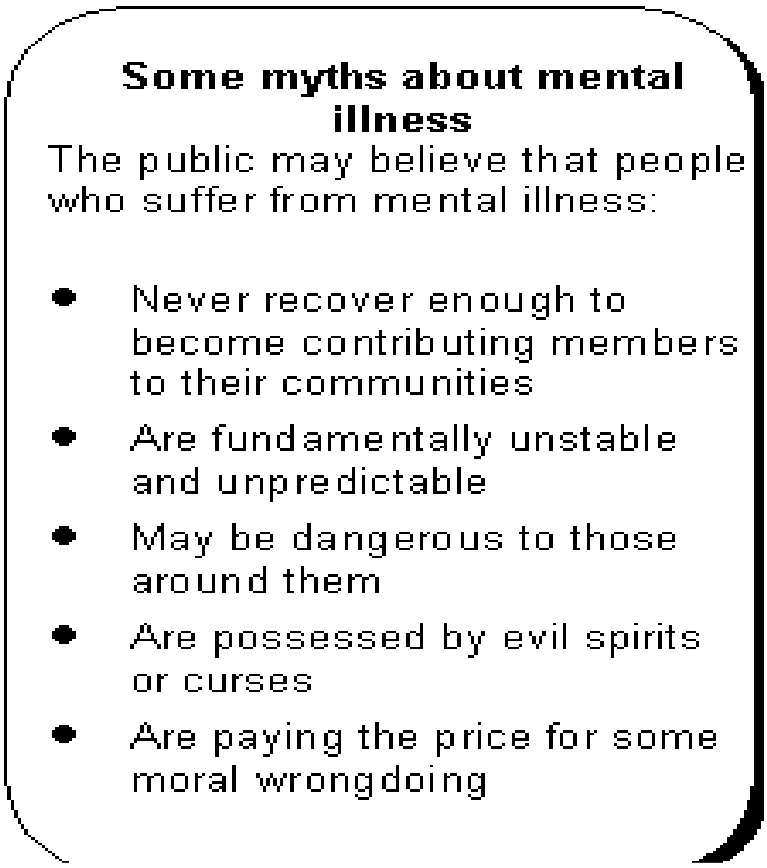

Fig. 1.8Myths about Mental Illness
Adapted from http://blogs.psychcentral.com

Psychiatry practice is the most humiliated branch of medical practice by people even among other health care professional because of the misconception people have about the psychiatry from its evolution as a specialty.

Pre-Scientific

People believe that:

(i) Psychiatric illness is due to evil causes
(ii) Mal-evilment of others e.g. witchcraft
(iii) That mental illness is a form of maltoment e.g. taboos.

Negative Attitudes

(i) Discrimination against mentally ill people – constituting popular jokes and mockery.
(ii) Rejection by family and society e.g. because of spoiling family name.
(iii) Rejection by society. He receives negative attitudes from colleagues on duty. Socially, he finds it difficult to mix with people; as people believe that they could also become psychiatric patient if they move freely with a mentally sick individual.
(iv) They are labeled by the public.
(v) Legal discrimination. Patients are kept in the asylum. They are compulsorily detained.

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

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

Another misconception is that because of the belief that mental illness has something to do with the appearance of "moon" – hence the word "lunatic" comes from the Latin word "lunar" = moon.

4.0 CONCLUSION

Being mentally healthy is also about having the strength to overcome the difficulties and challenges we can all face at times in our lives, to have confidence and self-esteem, to be able to take decisions and to believe in ourselves.

5.0 SUMMARY

You have just learned various definitions of terms like health, mental health and psychiatry in this unit, these terms are basic to your understanding of the subject of mental health and psychiatric nursing. The unit also identified the scope of psychiatry as a specialty in medicine with various sub-specialties such as: child and adolescent psychiatry, forensic psychiatry, geriatric psychiatry and others. Very important in the unit is discussions on the misconceptions people have about the field of psychiatry, and mental health and psychiatry been described as a team work that involves many health care professionals. .

6.0 TUTOR-MARKED ASSIGNMENT

Reflect on what you use to know about the concept of mental health and psychiatry and write the difference between what you use to know and what you now know. Interview 10 persons (3 men, 3 women, 2 male adolescents and 2 female adolescents) to find out what they know about mental health. Record your interview and share your findings with your group and facilitator on your discussion forum

SELF-ASSESSMENT EXCERCISE

i. Explain the concept of health.
ii. Define mental health.
iii. Describe the concept of mental health and psychiatric nursing.
iv. List various special fields of psychiatry.
v. What are the various misconceptions people have about psychiatry.

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UNIT 2 MENTAL HEALTH, HYGIENE AND ADJUSTMENT MECHANISM

CONTENTS

1.0 INTRODUCTION

You have learned about basic concepts in mental health and psychiatric nursing in the previous unit, now we are going to discuss some more important aspects of mental health that is mental health and hygiene. Mental health and hygiene is the two sides of a coin. Hygiene is the pre-requisite condition for maintaining good and sound health. Besides these, this unit also deals with the various mechanisms of adjustment. In fact, adjustments mechanisms are the instrument for maintaining the balanced personality as well as the instrument to rescue from the various mal-adjusted behaviours and problems.

You will learn more about the concept of mental health and hygiene which will enable you to identify factors affecting mental health and discuss the concept of maladjustment as it relates to mental health of an individual.

2.0 OBJECTIVES

At the end of this unit you will be able to:

- Explain the meaning and concept of mental health and hygiene
- Identify the factors affecting mental health
- Explain the concept of Mental Hygiene and its Characteristics
- Identify the Functions, Principles and limitations of Mental hygiene

- Discuss the concept of Adjustment Mechanism and the Causes of Maladjustment.

3.0 MAIN CONTENTS

3.1 Meaning of Mental Health

Fig. 2.1 Activities that lead to good mental healt http://mygrade7health.blogspot.com/2014/10/the-nature-of-mental-health.html

Mental health is defined as a state or condition on which an individual feels a sense of well-being. This gives him or her capacity to live life in fulfillment of what he or she wants to achieve in accordance to the available resources. This condition also provides an individual the capacity to be resilient to the stresses he meets and to respond to these challenges without having to compromise his well-being. This also makes him productive and fruitful for himself and his community.

The concept of mental health is as old as human beings. Our ancient scriptures are full of references to mental diseases. But this concept is comparatively new even in the West. Burmham who emphasizes the importance of integration or wholeness of personality said “a mentally healthy person is one who has a balanced personality, free from schism and inconsistencies, emotional and nervous tension, discords and conflicts.

A well adjusted person can deal with his potentialities as well as he can accept his limitations."

Characteristics of Mental Health

Different authors emphasize different characteristics of a mentally healthy person. These can be studied under following heads.
(A) Indian Views (B) Western Views

Indian View:
Indian concept of mental health is available in the Atharva Veda which provides detailed information on mental disorder and their treatment. According to Artha Veda mental personality consists of three gunas or characteristics: Sattya, Rajas and Tamas. The imbalance of these gunas causes mental disorder. These gunas are in the mind since birth, but they keep certain equilibrium in a normal person. So normal mental health means living in Rajas and Tamas to a certain degree.

The Charak Samhita and **Susrut** have also given the concept of mental health, but they do not differ significantly from the Atharva Veda's concept of mental health. These concepts of mental health are used in Aiurveda.
Western Concept: Though the concept of mental health is comparatively new yet different authors have given different views regarding sound mental health. Harry Stack Sullivaa says that a mentally healthy individual would place a major value on efficient social functioning.

Freudians lay emphasis on an awareness of one's unconsciousness motivations and subsequent self control, based on the awareness. Jahoda (1963), proposes six criteria of the mentally healthy individual. These are-

The ability to love adequately in interpersonal relationship, efficiency in meeting situation requirements; efficiency in problem solving. These also include;having undistorted perception of reality including empathy and social sensitivity; possessing a balance of psychic forces in the individual and a unifying outlook on life and resistance to stress; been able to make decision; growth, self development and self actualization including conception of self etc and attitude towards self concept and sense of identity.

From the above discussion we can easily distinguish between the mentally healthy and unhealthy person in the following ways –

Table 2.1: Mental health and mental illness compared

Mentally Healthy	**Mentally Unhealthy**
1.Aware about their self and have some respect for others	1. Not aware about their own self and have no respect for others
2. Understand one's own limitation and also can tolerate others limitation.	2. Can't understand one's own limitation and can't tolerate others limitation.
3. They can understand that all behaviour is causal.	3. They can't understand the cause of behaviour.
4. They can understand the basic needs that motivate behaviour.	4. They can't understand the basic needs which motivate behaviour.

Mental health is, thus, a condition of psychological maturity. It is a condition of personal and social functioning with a maximum of effectiveness and satisfaction. A mentally healthy person is responsible, self reliant and has a true sense of individuality. He has a realistic life goal as well as philosophy of life and values. He can differentiate between the right and the wrong.

According to Jacky Roy, a mentally healthy person possesses a good physical health. He can keep a good social relation too. He has insight into his action.

On the basis of the above discussion we can make the following observations.

Concept of mental health is subjective, Mental health is depending on sound physical health, Measurement of mental health is difficult as we don't have any standardMental health depends on many factors, Criteria of mental health may be different from country to country, Mental health is synonymous to balance personality, Mental health is a dynamic concept, and that Mental health is related with stress and strain of life.

3.2 Factors Affecting Mental Health

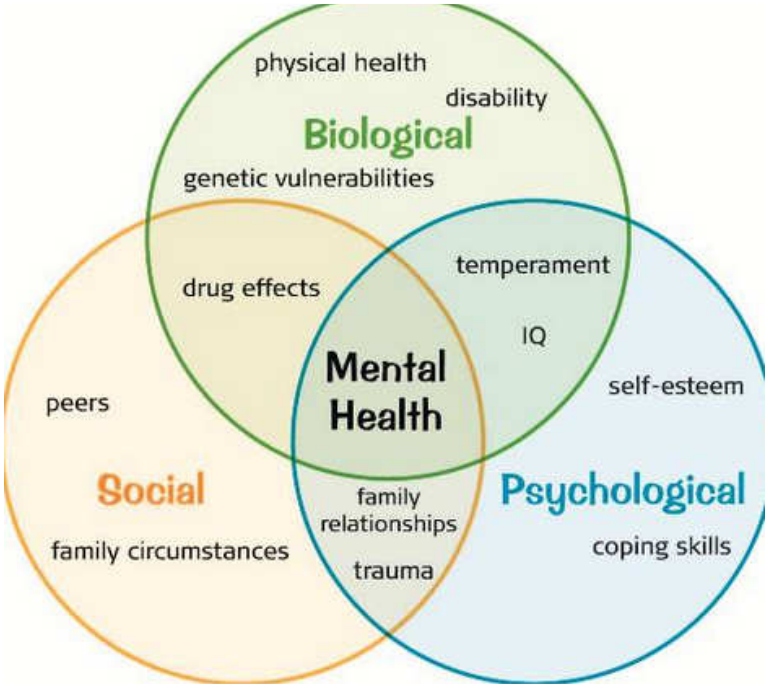

Fig. 2.2 Factors Affecting Mental Health
www.kidsmatter.edu.au

Let us look at the factors that affect mental health. Mental health plays a crucial role in the development of the personality but there are many factors which help in developing positive or negative development of mental health. Mental ill health is caused by different factors which have been described by different authors in different ways. Here we are presenting some of the models which explain the causes of mental ill health. These are:

- Socio Cultural Model
- Medical Model
- Psycho Analytical Model
- Behaviouristic Model
- Interpersonal Model

Socio Cultural Model emphasizes the role of social condition, such as poverty discrimination, casteism, violence etc. as the basic causes of poor mental health

Medical Model emphasizes the role of various organic conditions that affect our brain functioning.

Psycho Analytical model emphasizes the stress situations that involve a threat to the individual's psyche. It gives importance to early childhood experiences as a major factor for mental ill health.

Behaviouristic model gives importance to faulty learning such as the failure to learn necessary adaptive behaviour.

The interpersonal model emphasizes the unsatisfactory interpersonal relationship among human beings.

Besides these models, different authors have given some more causes to understand the factors responsible for ill mental health.

These factors are:

1. Primary
2. Predisposing
3. Precipitating
4. Reinforcing

The primary cause is the condition without which the mental ill health would have not occurred.

A **predisposing** cause is a condition that comes before and paves the way for later maladjustment For example: if a child is very much rejected in his early childhood, he may develop some mental disorder.

A **precipitating** cause is a condition that proves too much to bear for the individual and triggers maladaptive behavior. For example, the sudden death of one's father may cause mental disorder for that reason.

A **reinforcing** cause is a condition that tends to maintain the maladaptive behavior already present such as playing a 'sick role' and relieved from unwanted responsibility say for family.

Let us now mention the factors responsible for mental ill-health. They can be listed as shown below:

Hereditary
-Genetic defects, Chromosomal defects, Faulty genes, Constitutional liabilities- physique, physical handicap etc and Physical deprivation-Malnutrition, sleep disturbances emotional disruption, Brain pathology.

A. **Psychological**
   Factors here include; Mental deprivation; Institutionalization, Deprivation in Home, Defective family pattern structure etc., Early psychic Trauma and Severe stress.
B. Socio Cultural Factors
C. War and Violence
D. Group Prejudices
E. Economic and Employment Problems
F. Modernization and Globalization

3.3 Concept of Mental Hygiene

Mental hygiene is a Science which deals with the process of attaining mental health and preserving mental health in the society. The term mental health is closely related with the term mental hygiene as the main objective of mental hygiene is to attain mental health. In other words, mental hygiene is a means of mental health. That is why we can say that mental hygiene is the means and mental health is the end.

Definition:

There are many definitions of the term mental hygiene. Some of the definitions are mentioned below:

According to Klien, “Mental hygiene is an endeavour to aid people to ward off trouble as well as to furnish ways of handling trouble in intelligent fashion when it cannot be warded off.” To him, these troubles may be: Illness, finances, social Position, religion, sex, economic Security, old age, inadequate shelter etc.

According to Rivillin, mental hygiene
Means the application of a body of hygiene information and techniques; It is taken from the sciences of Psychology, Child psychology, Education, Sociology, Psychiatry, Medicine and Biology; It cares for the purpose of the preservation and improvement of mental health of the individual and community; It is meant for prevention and cure of minor and major mental diseases and defects of mental, educational and social maladjustment.

The History of mental hygiene is old as our civilization. In India, Ayurveda successfully developed a full fledged system for treating the mentally ill people long back. But in the West the mental hygiene movement started in the first decade of the 20th century. Clifford Beers, a graduate of Yale University can be regarded as the father of mental hygiene. He being frustrated with his life once attempted to commit suicide in the year 1908. But luckily he was saved and treated for his mental illness. After recovery he wrote a book entitled "A Mind That Found Itself"-where he described about his illness and the type of treatment he had received. This book created a revolution among the general public for the necessity of mental hygiene. Gradually many Institute of Mental Hygiene were established in India as well as in many other parts of the World to train personnel in the field of mental hygiene.

Mental Hygiene is a science. The main objective of mental hygiene is to build up one's ego rather than tearing down another's ego. It tries to develop the power of tolerance and praise and discourages the habit of blaming others. Hence, we can say that the approach of mental hygiene is positive rather than negative.
The main objectives of the mental hygiene can be summarized as shown below-

To help to realizes one's potentiality
Every individual possess certain potentialities. Mental hygiene tries to help each individual to develop his/her potentialities.

To develop self-respect and respect for others
Loss of self-respect is one of the factors for the great majorities of emotional disorders. A person who likes himself can like others and one who dislikes himself cannot like anybody. Hence, the main aim of mental hygiene is to help one to respect oneself.

To understand one's limitations and tolerate the limitations of others
Mental hygiene helps one to understand his own limitations as well as to tolerate others' limitations.

To cause harmonious development: Mental hygiene aims at the harmonious development of the physical mental and spiritual capacities of the individual so that he can adjust himself in the environment.

To create happiness: Another objective of mental hygiene is to develop a positive attitude towards life so as to create a sense of happiness in a person who can live happily in this world.

To enable one to make effective adjustment: Mental hygiene also prepares an individual for effective adjustment in all sphere of life and all situations such as in school, home, society work and also with self.

To enable one to know his or her self: Many of us do not know our own self. We are not at all aware about our potentialities, weaknesses, limitations etc. for which many individuals suffer from different types of confusion. Mental Hygiene helps an individual to know himself.

Functions of Mental Hygiene
Mental hygiene has four important functions. These are:

i. Prevention or preventive –The most important function of mental hygiene is to prevent mental health problems by developing some programmes.
ii. Creative – Another function of mental illness is to develop programme like counseling, psychotherapy to treat an individual or a group or to treat a mental patient.
iii. Preservative- Not all people are mentally ill; rather of them possess sound mental health. So the third function is to develop programme through education for preserving mental health.
iv. Training- Another function of mental hygiene is to train a set of personnel who can help the people with psychological problem by trying to understand their problems and then helping them to meet their needs.

Principles of Mental Hygiene
To formulate general principles of mental hygiene is a difficult task as there is a wide range of differences among the individuals. Some of the reasons for this are:

Human beings have multiple needs which grow in the course of development. These needs are contradictory in nature.
There is no single, absolute standard to judge human behaviour or action. However, in spite of these difficulties, we can formulate some general principles. These are:

Adjustment in home

Every child should develop such type of behavior at home so that he can adjust himself in any type of situation. Parents should take utmost care because the behavior patterns that develop in early childhood leave permanent impression on the child. Parents should try to develop the desirable traits in their children and develop competence, security, adequacy, self esteem and discipline by catering to their basic needs.

Adjustment in school

After home, school plays an important role in the development of personality. The school through its various activities can go a long way in creating an environment for the children to preserve and develop their mental health.

Adjustment to Society

Man is a social animal and he has to adjust himself with the society. Without proper social interaction, harmonious development of personality cannot occur. Hence, parent's, teacher and society must provide socially acceptable channels for the release of pent up emotional feeling so that the children and adolescents develop healthy personality.

Adjustment to work

According to Freud, one is mentally healthy, if one can work successfully. School through its programme, should develop the proper mental state towards work in children.

Limitations of Mental Hygiene

Though mental hygiene is an important aspect in our educational system, yet there are many limitations in implementing the principles of mental hygiene. Some of these are:

i. Majority of our parents are not aware about mental hygiene. Hence they do not give importance how to keep their children's mental health preserved and un- impaired.
ii. Teachers in our school system are so overloaded with work that they cannot devote time to organize different types of programmes which help the students in helping their mental health intact'
iii. There is also a dearth of trained personnel to deal with the mental health problems of our population.

3.4 Adjustment Mechanism

Every individual has different types of needs and goals which he always attempts to attain. But due to some external or internal factors it is not possible for him to achieve these goals all the time. In such cases sometimes, people may suffer from frustration. In such a situation an individual may react in different ways. He may attack physically the source of frustration to reduce his mental tension or he may destroy the object of frustration. He may use different mechanisms to beat his frustration and adjust himself to protect his ego. Thus adjustment mechanism is a device used to achieve an indirect satisfaction of a need in order to reduce his or her own tension. This mechanism is used by different individuals in their own ways. The types and frequency of the mechanism differ from individual to individual in his own ways. The types and frequency of the mechanism differ from individual to individual. For example, suppose a student wanted to become a doctor, but he could not manage a seat for the course. In that case he may become frustrated as he could not meet his desire. In such case he may behave in the different ways. He either opt for a para-medical course or may give up his studies or he may even opt for Arts course.

Generally, the normal people adopt a healthy mechanism, to protect his ego, which is more or less socially accepted.

Though there is no general agreement regarding the adjustment mechanism yet some common mechanisms are as follows:

Compensation
Compensation is a tendency of human being to make up the deficiency of one area or trait of development in another area. When a person fails in one area, he tries to compensate for his failure by trying to succeed in another area. The most potent example is Napoleon's drive for power. Probably his short figure and feminine build created in him a sense of inferiority which in turn made him a power monger. Compensatory behaviour is always based on the feeling of inadequacy. Compensation may be of the following types

Direct Compensation- It is a process when an individual removes his specific weakness and frustration in the same field by unusual effort. For example, a boy who is poor in Mahts may compensate directly when he tries to become strong in Maths by doing hard labour.

Over compensation- It is process when an individual moulds his outstanding weakness into an outstanding strength. Example-In spite of having early speech defect Demosthenes became a great orator by utilizing the mechanism of compensation.

Indirect Compensation- Many parents directed their children into vocations that they themselves aspired for but failed to get. A weak student who is poor in academic achievement may compensate in game.

Identification
It is a process by which an individual establishes a strong emotional tie With another person, A group of persons Or an institutions
Through such ties, he achieves his satisfaction. He draws his strength from the strength of others. As an example; we may mention how Infants identify themselves with their father or mother.

Adolescents identify themselves with some political leaders, youth leaders or actors or actress and attempt to acquire their characteristics. The Members of the family of a famous person usually identify themselves closely with him and so increase the feeling of their own importance.
Identification is not desirable as it makes an individual lose his own identity and individuality. If this mechanism is used excessively, it is apt to affect the mental health of an individual.

Rationalization: It is a mechanism by which an individual devises socially acceptable reasons for some socially unacceptable act or opinion, belief, faith etc. It is very difficult to have a wholly rational man. We generally colour our reasoning by emotional factors which impel us to rationalize in order that our actual behavior will appear in a better light in our eyes and in the eyes of others.

There are generally two types of rationalization. These are:

(a) Sour grapes
When an individual fails to attain his goals after repeated efforts, he may say that he did not want it any way. He adjusts to the frustration by denying the existence of any desire in him to attain the original goals. See the following examples:

A fox which could not reach the grapes and out of sheer frustration declares that grapes are sour.
A boy when he fails to qualify himself in the school football team rationalizes his failure by saying that he does not want to play.

(b) Sweet lemon

When an individual is not satisfied with his achievement or the situation he is in, then he uses this form of rationalization. The individual who uses this method tries to convince himself that what he has is exactly what he wants. The following examples make it clear.

A teacher before joining the teaching profession tried his best to get a better job than teaching but when he fails, he accepts teaching as a very good profession and thus rationalizes himself. Every child passes through the stage of saying 'No' to any request even though later he may carry out the assignment. If this refusal continues and if it is accompanied by tempertentrums, there is a danger that a permanent negative mechanism is in the process of development.

Daydreaming: This mechanism is used mostly by all people. An individual may turn to day /dreaming in order to satisfy a need which he is unable to satisfy. For example, an adolescent boy desires popularity but is not liked by his peer group. In that case he may imagine himself in his daydream as the centre of the group whom everybody admires.

Figure 2.3 Daydreaming
Source: www.gradydoctor.com

Day dream may be of two types
Table 2.2: Types of Day dream

a) Conquering hero type	b) Suffering hero type
In this type of daydream, the individual sees himself as confident and successful in all fields. For example, a person may see himself as a great musician who can make the audience spell bound.	In this type of daydream an individual develops sympathy for himself only. For example, a child who feels that he is being ill-treated at home may imagine himself as seriously ill.

Regression: It is a form of adjustment which involves a retreat from the complexities of the present to an earlier and simpler form of behavior. As example: an individual when frustrated can cry like a child and can have tempertantrums. The desire to regress is common to everyone, one example of which is selective forgetting.

Repression: In this mechanism an individual tries to repress the thoughts, experiences etc which are painful. Repression is an undesirable mental mechanism of adjustment because it is more tension producing than the tension reducing.

Projection: In this method an individual tries to defend himself against his repressed guilt feelings by projecting them into other things and people. Extreme use of projection is frequently observed in neurotic and psychotic personalities.

Causes of Maladjustment
Maladjustment is a complex problem of human behaviour. It is very difficult to find out the appropriate cause. Home, School and Society play an important role in causing maladjustment among the students. Freud, Adler Jung etc. described different factors for maladjustment. Some of those factors are given below:

Causes of Maladjustment: There are many causes of maladjustment. These can be categorised as:

a. Personal
b. Social
c. School factors

Physique: If a child is very weak, ugly and possesses sensory handicap he may suffer from different types of handicap which may cause maladjustment.

Poverty: Poverty is also an important factor which develops maladjustment among children. The main cause behind it is that in a poor home, the parents cannot fulfill the legitimate needs of heir children. Frustration owing to the non-fulfillment of the needs actually lead to maladjustment behavior.

Personal inadequacy: A nervous sense of inadequacy is a cause for mal-adjustment. Suppose a student is not so brilliant, but his parents are very ambitious and set high goals for them. This may lead him to frustration and as a result he may develop problems of maladjustment.

Parental attitude: If a child is rejected by their parents from an early childhood the child may develop the feeling of insecurity, helplessness and loneliness. Rejection and lack of affection may lead to maladjustment behavior.

Emotional shock: Children who experience emotional shocks, such as death, accident, riots, flood etc may manifest signs of maadjustment in their behavior.

Prolonged sickness and injury: Prolonged sickness may cause maladjustment among children.

Broken home: The children who come from broken homes (broken by death of parents, divorce and separation, physical or mental handicap) etc. may lead to maladjustment among children.

Social factors :
Religious Belief: In this era of modernization, adolescents often get confused about the traditional religious beliefs for which they do not find any rational basis and as a result suffer from a lack of positive attitude and get frustrated.

Mobility of Parents: Children whose parents move from one place to another very frequently face different types of problems. This may lead to maladjustment on the part of the children who suffer from a feeling of insecurity.

Employment insecurity: Uncertain about proper employment opportunities after getting higher degrees is another important factor for causing maladjustment among the students

c. School:

School conditions also play a vital role in the lack of adjustment of children. Some of the factors in the connection are:

Inadequate curriculum: Our present curriculum is not meeting the psychological, social as well as the physical needs of our children at different stages. These rather create frustration in our children as a result of which the children find themselves maladjusted in their real life situations.

Lack of proper recreational facilities: Children who are not getting scope for extra curricular activities like play, library, debates discussion etc may suffer from maladjustment problem.

Improper classroom climate: If there is no good relationship between students and teacher, as well as among the peers, the students may suffer from emotional problems, which in turn lead to maladjustment.

Inadequate training of teacher's for balancing the mental health and hygiene: The teacher's are not properly trained in Educational Psychology and mental hygiene; they face tremendous problems in handling the children. They cannot properly deal with the problems of their students. This result in the problems of maladjustment for the students

Interpersonal relationship among the staffs

If there is cooperation and mutual understanding among the administrator, teachers and other staff in an educational institution one finds a very conducive environment which helps develop good mental health. But this is lacking in most of the schools. Our educational institutions are be set with various problems of caste, creed, religion and regional feelings. It is not unusual for the students to suffer from serious problems of mental health under such circumstances. There is favoritism, partial treatment on the basis of caste, creed religion, and region etc. which affects mental health of the student's body.

4.0 CONCLUSION

Mental health is a state or condition on which an individual feels a sense of well-being.

5.0 SUMMARY

After going through this unit, the followings are the basic points that we have learnt.

i. Mental health and mental hygiene are related to each other. Mental hygiene is the means and mental health is the end.
ii. Mental health to a great extent depends on sound physical health.
iii. Criteria of mental health differ from society to society
iv. Consistency in behavior is one of the important characteristic of sound mental health.
v. The fulfillment of four basic needs like physical security, emotional security achievement and status is essential for having good mental health.
vi. "Know thyself" is sound mental hygiene.
vii. An experience which develops one's feeling of worth and self-esteem is very helpful in preventing maladjustments.
viii. Adjustment can be viewed from two aspects, i.e. adjustment as achievement and adjustment as a process.
ix. Adjustment as an achievement means how efficiently an individual can perform his duties in different circumstances and adjustment as process means how a child gradually interacts with his environment and adjusts himself accordingly with different situations. According to different psychologists the criteria of good adjustment are physical health, psychological comfort, work efficiency and social acceptance.
x. Some of the common adjustment mechanisms are: Compensation, Identification, Rationalization, Negativism, Day dreaming, Regression, Repression and Projection.
xi. Personal factor, Social factor and School factor are the three basic causes for mal-adjustment.

6.0 TUTOR-MARKEDASSIGNMENT

Identify the mental health mechanisms discussed in this unit and discuss with examples of situation in which each mechanism is displayed in your study group.

SELF ASSESSMENT EXERCISE

i. Explain the meaning and concept of mental health and hygiene.
ii. What are those factors affects mental health.

iii. Discuss the concept of Mental Hygiene and its Characteristics.
iv. Identify the Functions, Principles and limitations of Mental hygiene.
v. Discuss the concept of Adjustment Mechanism and the Causes of Maladjustment.

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UNIT 3 CHARACTERISTICS OF MENTAL HEALTH

CONTENTS

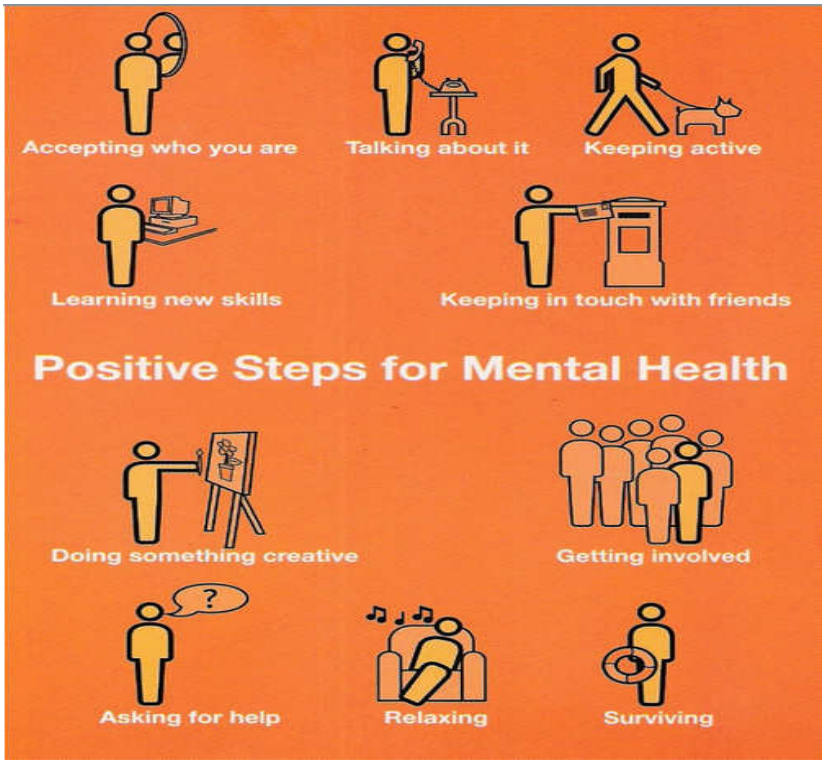

Fig. 3.1 Positive mental health
Source: http://www.ugproi.com/en/our-work/mental-health/news-on-mental-health/how-to-have-positive-impact-on-mental-health

1.0 INTRODUCTION

Mental health is more than just the absence of mental illness. It includes how you feel about yourself and how you adjust to life events. This unit will examine the characteristics of positive mental health, factors in the maintenance of emotional health and suggestions for improving positive mental health. I do hope that this unit will be helpful to you as a person and as a nurse who will be involved in behavioural modification of people to enhance a better living.

2.0 OBJECTIVES

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

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

3.0 MAIN CONTENTS

3.1 Characteristics of Positive Mental Health

Mental health is generally agreed to be more than just the absence of a mental illness. The World Health Organization (WHO) defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community." The Public Health Agency of Canada (PHAC) has also adopted a broad definition: "Mental health is the capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity.

Good mental/emotional health is characterized by:

1. The possession of the ability and capacity to keep 'going' when life seems most uncertain, and a refusal to go into pieces in time of crisis;
2. Keeping an open mind and not jumping into hasty conclusions about any issue you are concerned with directly or indirectly;

3. Making a thorough analysis of a given situation before embarking on any important action. A thoughtful and calculated action pays off better;
4. Displaying well founded self-confidence while being realistic about your limitations; being aware of your strong point when you formulate your plans and prepare to take advantage of your strength;
5. Avoiding excuses for not making genuine efforts that are calculated to put the 'other person' at fault;
6. Being able to learn from experience of others, for this saves you a considerable amount of time in the long-run;
7. Being able to sieve the important from the unimportant issues, so that you do not waste your time on the unimportant ones;
8. Desisting from any display of 'big shot' behaviour which is an obvious manifestation of insecurity;
9. Facing real issues at stake and avoiding taking response in issues that have no relevance to what is at stake in an attempt to shift blame that is squarely yours.

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

They listed the following characteristics:

1. **Ability to deal constructively with reality**
   One of the signs of good emotional health is the acceptance of reality whether pleasant or otherwise. A person who accepts reality does not generally attempt to escape from reality by mental fantasy. According to Jones, Shainberg and Byer (1974), dealing constructively with reality means learning to acknowledge and accept one's own capabilities and limitations.
2. **Ability to adapt to changes**
   The basic need for safety and security is largely responsible for the natural tendency to resist change. But a healthy person is confident of his ability to adapt to change because he realizes that the only thing permanent is change itself. He therefore expects change and plans ahead to adapt to it.

3. **Ability to make long-range choices**
   Good emotional health requires giving up some immediate pleasures for the sake of long-term values. This is an important characteristic of a self-actualised person who has certain goals for the future and realizes he must make sacrifices for the moment in order to reach the long-term goals.
4. **Reasonable degree of autonomy**
   The ability to function autonomously, to think for oneself and to make decisions and accept responsibility for the consequences are characteristics of good emotional health. Inability to make decisions for fear of mistakes is a sign of immaturity and insecurity. This characteristic does not completely rule out the need for dependence some time, for in our complex society we are depending on other people in many ways. Inter-dependency is also a sign of good emotional health.
5. **Concern for other people**
   An emotionally healthy person combines self-respect with a concern for the rights and happiness of other people. There is as much satisfaction in giving as in receiving. A healthy person readily accepts the differences he finds in other people and accepts them as they are.
6. **Satisfactory relationship with other people**
   An establishment of satisfactory relationship with other people is closely related to concern for other people. A person who enjoys good emotional health is able to interact in a consistent manner with mutual satisfaction and happiness. He trusts most people and expects that people will equally like and trust him. He has lasting relationships with other people. He feels accepted as he makes others feel accepted.
7. **The ability to love**
   A mentally/emotionally healthy person exudes love; not just the selfish love, but that which is unselfish. It is the emotionally rewarding expression of affection for other people. It is a love for humanity, which only a person with a well-developed sense of inner security can freely express.
8. **The ability to work productively**
   One of the prime indicators of good emotional health is the ability to work effectively and productively. Conversely, inability to be productive may be a sign of mental/emotional illness.

3.2 Factors in the Maintenance of Emotional Health

Everyone is entitled to the satisfaction of his emotional health needs and at the same time, every person has needs to learn the effective emotional patterns of behaviour. A person's physical as well as emotional stability depends not only on the satisfaction of basic emotional needs and learned pattern of behaviour but also effective maintenance of emotional health.
But the crucial question is "how does one know he is on the right track of emotional health?" An attempt to answer this question has been done by Rice and Hein (1954) who pointed out that in spite of a lack of clear- cut rules; constructive suggestions could be made on which there is good general agreement. With these general agreements in mind as a basis for intelligent action, they contend that each person could condition his own behaviour so as to use his emotional energies to the best possible advantage. Such suggestions must be applied on an individual basis because of the individual differences. Emotional maturity, they further stated could be achieved only when each individual thinks and acts, which provide an effective adjustment to life, both for the immediate and for the future.

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

1. **Developing wholesome attitude to life**
   Developing interest in a variety of activities is an important step in the development of wholesome attitude to life. A student who devotes all his time on academic work or a gifted sportsman who spends all his time on the sports field or a social butterfly who spends all her time partying, cannot be said to be developing a wholesome attitude to life. Having a wholesome attitude also involves a thorough analysis of problems with an open and objective mind. It is important to study how others have solved problems, to make tentative plans on how to solve your own problems, to try out the plans while checking the results carefully. You should also be aware of the possibility of failure in order not to be grossly disappointed or discouraged when the first attempt does not result in success.

2. **Building emotional stability**
   Everyone is constantly faced with situations which arouse very strong emotions which are often bottled up. Such a situation may lead to very serious physiological and psychological consequences. Seeking a positive diversion has been suggested as a worthwhile

solution. Such suggestions include participation in vigorous physical activities, unburdening yourself to a trusted friend, a relation or a leader of your religious group. A sympathetic listener can do a world of good in reducing personal conflicts and pent up emotions. When you can talk freely about your problems to a willing listener, some of the emotional tensions which were previously stored within you will be given an outlet. Fears, anxiety, failures and anger often detract from emotional stability. Failure is not always bad; same as stress, but like uncontrolled stress, if you allow a failure to lead to insecurity and fear of possible failure, or allow failure to weigh you down, the effects can lead to disequilibrium of your emotional stability.

3. Learning to face reality

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

4. Setting suitable or realistic goals

Ability to set goals to be achieved in whatever one does is a mark of good mental health. Such goals may be set for a day, a week, a month or a year. Goal setting requires that the person works to accomplish the goal. You must be aware of the impact of goal setting on emotional stability. You should therefore constantly evaluate your strong and weak points objectively and carefully in order to ensure the successful achievement of your set goal or target.

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

5. Working for achievement

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

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

6. Improving skills in human interactions

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

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

Approaching friendship with this type of open-mindedness has a reciprocal effect, for it contributes to the mental and emotional health of individuals experiencing this mutual friendship.

7. Accepting limitations

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

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

8. Ability to seek for professional help

Family members, trusted friends and ministers of one's religious faith have earlier been suggested as persons who can be taken into confidence in the event of problems that might be impinging on an individual's mental health. Outside these persons are those who are professionally trained to handle the different levels of mental/emotional health problems. These are guidance counselors, psychiatric nurses, social health workers, psychologists and psychiatrists. Even the psychiatrist whose main concern is the treatment of serious mental cases, have now directed that efforts should be made to take preventive measures against mental and emotional illness. Seeking help for mental and emotional health problems seem to have a social stigma in Nigeria, as elsewhere. But this should not be and should be regarded as any other illness. Since people now have less time for one another in this country, which is

most unfortunate, it is necessary that a troubled person should seek out professional help before things get out of hand. The fact that a person sees a psychologist or psychiatrist does not necessarily make the person a 'mental case'. It does mean one is aware he has problems, the nature of which he cannot discern and needs professional assistance to help him understand what is happening and how to cope with the problems and how to avoid any future occurrence.

3.3 Suggestions for Improving Positive Mental Health

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

Individuals should:

a) Be well educated and understand the essence of positive Mental Health.
b) Abstain from use of dangerous drugs.
c) Avoid religious fanatism.
d) Try to show understanding in terrifying issues and approach same maturely.
e) Donate generously (i.e. wealthy individuals) to assist or complement government's efforts in the funding of Healthcare.

Government should try to:

i. Provide adequate hospitals, health workers, drugs and materials
ii. Health – educates the populace via the use of radio, television, posters, organize symposium and seminars
iii. Provide employment and security for people
iv. Adequate funding of the total health care industry.

4.0 CONCLUSION

The World Health Organization (WHO) defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."

5.0 SUMMARY

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

6.0 TUTOR-MARKED ASSIGNMENT

Critically examine yourself to see how many of the attributes mentioned above you possessed. Observe the same in two other persons and discuss with your discussion group members.

SELF-ASSESSMENT EXCERCISE

i. List the characteristics of positive mental health.
ii. Discuss each of the characteristics listed above.

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UNIT 4 CURRENT ISSUES AND TRENDS OF CARE IN MENTAL HEALTH

CONTENTS

1.0 INTRODUCTION

This unit will expose you to various challenges faced by mental health and psychiatric nurses in their day to day professional duties because of changes in patient care approach. This unit will assist you in getting more understanding of these challenges which will enable you meet the needs of the clients in need of mental health and psychiatric services.

2.0 OBJECTIVES

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

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

3.0 MAIN CONTENTS

3.1 Current Issues and Trends in Nursing Cares

Fig. 4.1; Factors that cause changes in the role of Nurses
https://www.google.com/search

A mental health and psychiatric nurse faces various challenges because of changes in patient care approach. Some of these changes that affect her role evolved as a result of the following:

Demographic changes

i. Type of family (increased number of nuclear families)
ii. Increasing number of the elderly group.

Social changes

i. The need for maintaining intergroup and intra-group loyalties
ii. Peer pressure.

Economic changes

i. Industrialization
ii. Urbanization
iii. Raised standard of living

Technological changes

i. Mass media
ii. Electronic systems
iii. Information Technology

Mental health care changes

i. Increased public awareness regarding mental health
ii. Need to maintain mental stability
iii. Increased mental health problems

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

Educational programmes for the psychiatric nurse
Diploma in Psychiatric Nursing
M.Sc in Psychiatric Nursing
M. Phil. In Psychiatric Nursing
Doctorate in Psychiatric Nursing
Short-term training programmes for both the degree and diploma holders in nursing

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

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

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

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

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

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

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

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

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

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

Psychiatric Nurse Educator
The main function of psychiatric nurse educator is planning and changing the curriculum according to the needs of the society and learner. The Nursing Council included psychiatric nursing as compulsory for the qualifying examination in all nursing training programmes.

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

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

Child Psychiatric Nursing
In child psychiatric nursing the nurse identifies the emotional and behavioural problems of the children and provides comprehensive care.

Gerontological and Geriatric Nursing
Gerontological nursing provides emotional support to those people who have retired from services, who have no financial sources and helps them in understanding the situation and developing new coping mechanisms.
Geriatric nursing is expanding the psychiatric nursing practice to aged people who have been affected by emotional and behavioural disorders such as dementia, chronic schizophrenia, delirium etc.

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

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

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

3.2 Mental Health and Psychiatric Nursing Skills

Table 4.1: Knowledge Skill and Abilities of A Mental Health And Psychiatric Nurse

KNOWLEDGE: • Psychology: Knowledge of human behaviour and performance, individual differences in ability, personality and interest, learning and motivation, psychological research methods, the assessment and treatment of behavioural and affective disorders. • Therapy and counseling; Knowledge of principles, methods and procedures for diagnosis, treatment and rehabilitation of physical and mental dysfunctions, and for career counseling and guidance. Public safety and security; Knowledge of relevant equipment, policies, and strategies to promote effective local, state or national security operations for the protection of people, data, property and institutions.
SKILS: • Active listening: Giving full attention to what other people are saying, taking time to understand the points being made, asking questions as appropriate, and not interrupting at inappropriate times. • Social perceptiveness: Being aware of other's reactions and understanding why they react as they do. Service orientation: Actively looking for ways to help people.
ABILITIES: • Oral Comprehension: The ability to listen to and understand information and ideas presented through spoken words and sentences. • Problem Sensitivity: The ability to tell when something is wrong or is likely to go wrong. It does not involve solving the problem, only recognizing there is a problem. Oral Expression: The ability to communicate information and ideas in speaking so others will understand.

Source: http://resumejobdescription.com/Sample-Knowledge-Skills-And-Abilities-Template.asp

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

Prerequisites for a Mental Health Nurse
Personal skills

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

Adaptability-A mental health nurse needs to be adaptable to different settings and cultures. Working within residential settings, for example, may demand attitudes and roles which are different from working in a community, as in a residential setting the nurse may have an authoritative or a supervisory role which she necessarily does not have in a community.
A mental health nurse also needs to cope with a variety of social and cultural settings. Social settings involve the class and status of the individuals while cultural settings involve race, ethnicity and gender. Therefore she may need to be familiar with the issues that arise in cross-cultural mental health nursing.

Care values and attitudes
These includes:

a. Self-awareness and self-esteem
b. Respecting other person's right
c. Listening
d. Responding with care and respect
e. Supporting with trust and confidence
f. Reassuring with explanation and honesty
g. Physically nursing the helpless with compassion
h. Carrying out procedures skillfully
i. Working within personal and ethical boundaries

Counseling skills
These includes:
a. Unconditional positive regard/non judgmental approach
b. Empathy
c. Warmth and genuineness
d. Confidentiality
e. Non-verbal sensitivity, non-verbal attending, non-verbal responding
f. Other interpersonal skills required are paraphrasing, reflecting, clarifying, summarizing.

Behavioural skills

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

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

Supervisory skills

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

Crisis skills

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

Teaching skills

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

3.3 Standards of Mental Health Nursing

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

Professional Practice Standards

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

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

Standard III: Diagnosis
The nurse utilizes nursing diagnosis and/or standard classification of mental disorders to express conclusions supported by recorded assessment data and current scientific premises.
Nursing logic basis for providing care rests on the recognition and identification of those actual or potential health problems that are within the scope of nursing practice.

Standard IV: Planning
The nurse develops a nursing care plan with specific goals and interventions delineating nursing actions unique to each client's needs.
The nursing care plan is used to guide therapeutic intervention and effectively achieve the desired outcomes.

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

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

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

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

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

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

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

Professional Performance Standards
Standard VII: Peer Review
The nurse participates in peer review and other means of evaluation to assure quality of nursing care provided for clients.

Standard VIII: Interdisciplinary Collaboration
The nurse collaborates with other health care providers in assessing, planning, implementing and evaluating programs and other mental health activities.

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

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

3.4 General Principles of Mental Health and Psychiatric Nursing

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

1. Patient is accepted exactly as he is
   Accepting means being non-judgmental. Acceptance conveys the feeling of being loved and cared. Acceptance does not mean complete permissiveness but setting of positive behaviours to convey to him the respect as an individual human being. A nurse should be able to convey to the patient that she may not approve everything what he does, but he will not be judged or rejected because of his behaviour.
   Acceptance is expressed in the following ways:

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

   (b) Being sincerely interested in the patient
   Being sincerely interested in another individual means considering the other individual's interest.

   This can be demonstrated by:

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

   (c) Recognizing and reflecting on feelings which patient may express
   When patient talks, it is not the content that is important to note, but the feeling behind the conversation, which has to be recognized and reflected on.

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

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

(e) Listening

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

(f) Permitting patient to express strongly-held feelings

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

2. Use of self-understanding as a therapeutic tool

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

3. Consistency is used to contribute to Patient's security

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

4. Reassurance should be given in a subtle and acceptable manner

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

5. Patient's behaviour is changed through emotional experience and not by rational interpretation.

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

6. Unnecessary increase in patient's anxiety should be avoided

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

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

7. Objective observation of patient to understand his behaviour
   Objectivity is an ability to evaluate exactly what the patient wants to say and not mix up one's own feelings, opinion or judgment. To be objective, the nurse should indulge in introspection and make sure that her own emotional needs do not take a precedence over patient's needs.
8. Maintain realistic nurse-patient relationship
   Realistic or professional relationship focuses upon the personal and emotional needs of the patient and not on the nurse's needs. To maintain professional relationship the nurse should have a realistic self-concept and should be able to empathize and understand the feelings of the patient and the meaning of behaviour.
9. Avoid physical and verbal force as much as possible
   All methods of punishment must be avoided. If the nurse is an expert in predicting patient behaviour, she can mostly prevent an onset of undesirable behaviour.
10. Nursing care is centred on the patient as a person and not on the control of symptoms
    Analysis and study of symptoms is necessary to reveal their meaning and their significance to the patient. Two patients showing the same symptoms may be expressing two different needs.
11. All explanations of procedures and other routines are given according to the patient's level of understanding
    The extent of explanation that can be given to a patient depends on his span of attention, level of anxiety and level of ability to decide. But explanation should never be withheld on the basis that psychiatric patients are not having any contact with reality or have no ability to understand.
12. Many procedures are modified but basic principles remain unaltered
    In psychiatric nursing field, many methods are adapted to individual needs of the patient, but the underlying nursing scientific principles remain the same. Some nursing principles to be kept in mind are: safety, comfort, and privacy, maintaining therapeutic effectiveness, economy of time, energy and material.

3.5 Functions of a Mental Health and Psychiatric Nurse

Fig. 4.2 The Psychiatric Nurse
Source: **http://www.nursebuff.com/wp-content/uploads/2014/09/Stress-**

Reduction-Methods-nursing-mnemonics.jpg

- Assessing the client and planning nursing care.
- Providing safe nursing care, including medication administration and participation in various therapies, individual interactions, formal and informal group situations, role-playing, advocating on behalf of the client, and so forth.
- Providing a safe environment, including protecting the client and others from injury.
- Accurately observing and documenting the client's behaviour.
- Providing feedback to the client based on observations of his behaviour.
- Teaching the client and significant others.
- Involving the client and the client's significant others in the nursing process.
- Providing opportunities for the client to make his own decisions and to assume responsibility for his emotions and life.

- Cooperating with other professionals in various aspects of the client's care; thereby, facilitating an interdisciplinary approach to care.
- Continuing nursing education and the exploration of new ideas, theories and research.

4.0 CONCLUSION

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

5.0 SUMMARY

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

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

6.0 TUTOR-MARKED ASSIGNMENT

Apply the skills discussed in this unit in your interaction with two clients in the courseof the week and share your experience with your discussion group members.

SELF-ASSESSMENT EXERCISE

1. Outline some of the changes that affect nurses role in relation to Demographic and Technological changes
2. What are your roles as a mental health and psychiatric nurse?

7.0 REFERENCES/FURTHER READING

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

Morrison-Valfre, M. (2005). *Foundations of Mental Health Care*. Missouri: Mosby Inc.

MODULE 2 MENTAL ILLNESS

UNIT 1 MENTAL ILLNESS

CONTENTS

1.0 INTRODUCTION

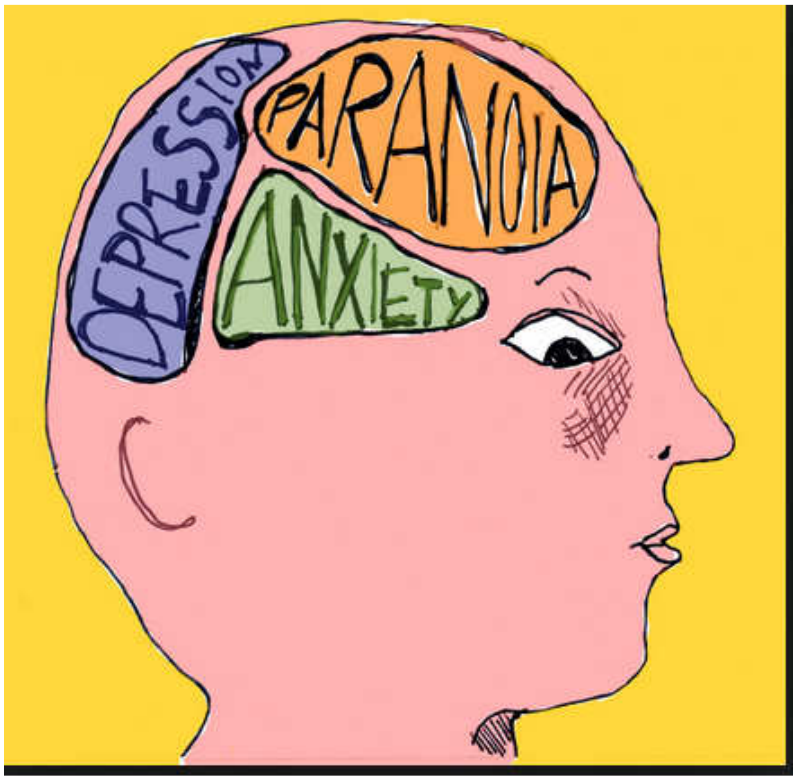

Fig. 5.1 Mental Illness
Source: www.healthworks.

There is more to good health than just a physically healthy body; a healthy person should also have a healthy mind. A person with a healthy mind should be able to think clearly, should be able to solve the various problems faced in life, should enjoy good relations with friends, colleagues at work and family, and should feel spiritually at ease and bring happiness to others in the community. It is these aspects of health that can be considered as mental health.

Even though we talk about the mind and body as if they were separate, in reality they are like two sides of the same coin. They share a great deal with each other, but present a different face to the world around us. If one of the two is affected in any way, then the other will almost certainly also be affected. Just because we think about the mind and body separately, it does not mean that they are independent of each other. Just as the physical body can fall ill, so too can the mind. This can be called mental illness.

We all experience stressful events from to time that can change our normal behaviour. This can include things like a relative dying, losing a job or a relationship ending. We may feel stressed, angry or sad, which are all natural responses but will probably only be temporary.

Sometimes changes in behaviour can suggest that someone is developing a mental illness. Typically, a mental illness rarely comes out of the blue. You may be the best judge when someone you know is behaving differently. You may notice a change in behaviour over a short period of time or over a number of months.

This module will provide you with more information on the concept of mental illness, the causes and general manifestations as well as the prevention of metal disorders.

2.0 OBJECTIVES

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

- differentiate between mental health and mental illness
- discuss various classification systems for mental illness
- describe the general aetiology and manifestations of mental illness
- describe mental illness
- identify factors that influences mental health
- discuss the burden for mental illness
- explain common types of mental health problems
- analyse the influence of culture on mental illness
- discuss promotion of mental health and prevention of mental illness.

3.0 MAIN CONTENT

3.1 Meaning of Mental Illness

Mental illness refers to a wide range of mental health conditions — disorders that affect your mood, thinking and behavior. Examples of mental illness include depression, anxiety disorders, schizophrenia, eating disorders and addictive behaviors.

Many people have mental health concerns from time to time. But a mental health concern becomes a mental illness when ongoing signs and symptoms cause frequent stress and affect your ability to function.

A mental illness can make you miserable and can cause problems in your daily life, such as at work or in relationships. In most cases, symptoms can be managed with a combination of medications and counseling Mental illness is any illness experienced by a person which affects their emotions, thoughts or behaviour, which is out of keeping with their cultural beliefs and personality, and is producing anegative effect on their lives or the lives of their families.

There are two important points that are needed to be emphasized here:

There have been tremendous advances in our understanding of the causes and treatment ofmental illnesses. Most of these treatments can be provided effectively by mental health professionals.

Mental illness includes a broad range of health problems. For most people, mental illness isthought of as an illness associated with severe behavioural disturbances such as violence, agitation and being sexually inappropriate. Such disturbances are usually associated with severemental disorders. However, the vast majority of those with a mental illness behaviours and looks are not different from anyone else. These common mental health problems include depression, anxiety, sexual problems and addiction.

3.2 Relationship between Mental Health and Mental Ill-Health

Mental health and mental ill-health are influenced by one another but are not polar opposites. That means, the absence of mental health does not necessarily mean the presence of mental ill-health, any more than the presence of mental ill-health implies a complete absence of mental health. While it does not reflect the interplay between mental health and mental ill-health, the Dual Continua Model of Mental Health shows how mental health and mental ill-health belong to two interconnected but separate continua. According to this view, a person may still have good mental health and wellbeing while living with a diagnosed mental illness. In the same way, a person may have significant problems with their mental health but not meet the criteria for a diagnosed mental illness. This approach is being adopted in promotion and prevention policy in a number of countries, including Scotland, Wales, England and Canada.

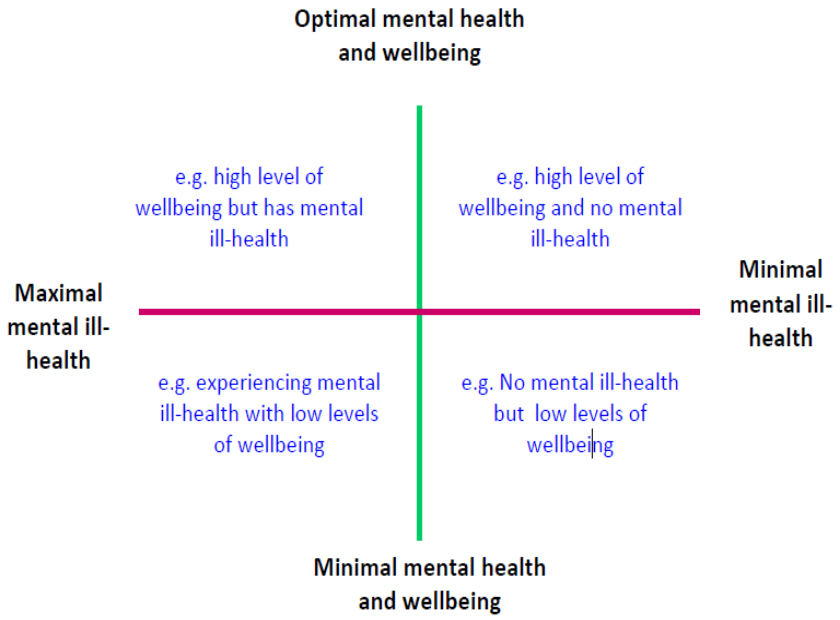

Figure 5.2: Dual continua Model of mental Health (Adapted from Tudor 1996)

3.2.1 Influences on Mental Health

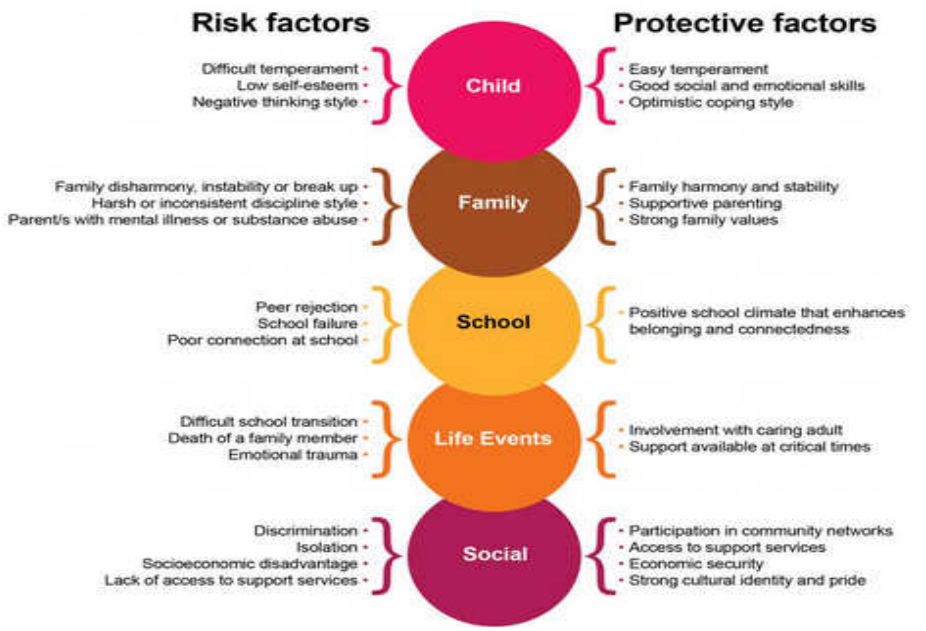

Fig. 5.3 Factors contributing to mental health of a child
Source: www.kidsmatter.edu.au

3.2.2 Determinants of mental health

Mental health is influenced by multiple biological, psychological, social and environmental factors which interact in complex ways. The factors that determine, or influence, mental health have been clustered into three key areas:

i. **Structural level factors** include social, economic and cultural factors that are supportive of positive mental health, such as safe living environments, employment, and education;
ii. **Community level factors** include a positive sense of belonging, activities to highlight and embrace diversity, social support and participation in society;
iii. **Individual level factors** such as the ability to manage thoughts and cope with stressors.

3.2.3 Risk and protective factors

The determinants of mental health can be expressed as risk and protective factors that are associated with the mental health of individuals and population groups:

Risk factors increase the likelihood that mental health problems and illnesses will develop, or increase in duration or severity when a mental illness occurs. Some risk factors play a causal role in mental illness (e.g. exposure to a traumatic event is linked to the development of ost-traumatic stress disorder) while other risk factors may be indicators that an individual is at higher risk (e.g. the higher risk of depression generally in the postnatal period).

Protective factors enhance and protect mental health and reduce the likelihood an illness will develop. Protective factors enhance an individual's ability to cope with stressors and enjoy life. Some protective factors are internal, such as a person's temperament, while others are external, related to social, economic and environmental supports.

3.2.4 Why Should you be Concerned about Mental Illness?

There are many reasons why you need to be concerned about mental illnesses.
Because they affect us all. It is estimated that one in five of all adults will experience a mental health problem in their lifetime. This shows how common mental health problems are. Anyone can suffer a mental health problem.

Because they are a major public health burden. Studies from nearly every corner of the world show that as much as 40% of all adults attending general health care services are suffering from some kind of mental illness. Many of the people attending general or community health services seek help for vague physical health problems, which may be called 'psychosomatic' or something similar. Many of them are actually suffering from a mental health problem.Because they are very disabling. Even though the popular belief is that mental illnesses are less serious than physical illness, they do in fact produce severe disability. They can also cause death, as a result of suicide and accidents. Some people suffer from a mental illness and a physical illness in such persons the mental illness can make the outcome of the physical illness worse. The World Health Report from the World Health Organization in 2001 found that four out of the ten most disabling conditions in the world were mental illnesses. Depression was the

most disabling disorder, ahead of anaemia, malaria and all other health problems.Because mental health services are very inadequate. There is a severe shortage of psychiatrists, psychologists and other mental health professionals in most countries. These specialists spend most of their time caring for people who suffer from severe mental disorders ('psychoses'). These are quite rare, but are also the very diseases that the community associates with mental illness. Most people with the much commoner types of mental health problems, such as depression or alcohol problems, would not consult a mental health specialist. General health workers are ideally placed to treat these illnesses.

Because our societies are rapidly changing. Many societies around the world are facing dramatic economic and social changes. The social fabric of the community is changing as a result of rapid development and the growth of cities, migration, widening income inequality, and rising levels of both unemployment and violence. These factors are all linked to poor mental health.

Because mental illness leads to stigma. Most people with a mental health problem would never admit to it. Those with a mental illness are often discriminated against by the community and their family. They are often not treated sympathetically by health workers.

Because mental illness can be treated with simple, relatively inexpensive methods. It is true that many mental illnesses cannot be 'cured'. However, many physical illnesses, such as cancers, diabetes, high blood pressure and rheumatoid arthritis, are also not curable. Yet, much can be done to improve the quality of life of those who suffer these conditions and the same applies to mental illness.

3.2.5 Symptoms of Mental Illness

To detect and diagnose a mental illness, you have to depend almost entirely on what people tell you. The main tool in diagnosis is an interview with the person. Mental illness produces symptoms that sufferers or those close to them notice. There are five major types of symptoms:

Physical – 'somatic' symptoms. These affect the body and physical functions, and include aches, tiredness and sleep disturbance. It is important to remember that mental illnesses often produce physical symptoms.

Feeling – emotional symptoms. Typical examples are feeling sad or scared.

Thinking – 'cognitive' symptoms. Typical examples are thinking of suicide, thinking that someone is going to harm you, difficulty in thinking clearly and forgetfulness.

Behaving – behavioural symptoms. These symptoms are related to what a person is doing. Examples include behaving in an aggressive manner and attempting suicide.

Imagining – perceptual symptoms. These arise from one of the sensory organs and include hearing voices or seeing things that others cannot ('hallucinations').

In reality, these different types of symptoms are closely associated with one another.

3.2.6 Categories of Mental Illness

There are five broad categories of mental illness:

1. common mental disorders (depression and anxiety);
2. severe mental disorders (the psychoses);
3. mental retardation;
4. mental health problems in the elderly;
5. mental health problems in children.

3.2.6.1Common mental disorders (depression and anxiety)

Common mental disorders consist of two types of emotional problems: depression and anxiety. Depression means feeling low, sad, fed up or miserable. It is an emotion that almost everyone suffers from at some time in their life. To some extent it can be thought of as 'normal'. But there are times when depression starts to interfere with life and then it becomes a problem. For example, everyone gets spells of feeling sad but most people manage to carry on with life and the spell goes away. Sometimes, however, the depression lasts for long periods, even more than a month. It is associated with disabling symptoms such as tiredness and difficulty concentrating. The feeling starts to affect daily life and makes it difficult to work or to look after small children at home. If depression starts to get in the way of life and lasts for a long period of time, then we can assume that the person is suffering from an illness. The key features of depression are :
A person with depression will experience some of the following symptoms:

Physical
- tiredness and a feeling of fatigue and weakness
- vague aches and pains all over the body

Feeling
- feeling sad and miserable
- a loss of interest in life, social interactions, work, etc.
- guilty feelings

Thinking
- hopelessness about the future
- difficulty making decisions
- thoughts that he is not as good as others (low self esteem)
- thoughts that it would be better if he were not alive
- suicidal ideas and plans
- difficulty in concentrating

Behaving
- disturbed sleep (usually reduced sleep, but occasionally too much sleep)
- poor appetite (sometimes increased appetite)
- reduced sex drive

3.2.6.2Anxiety

Anxiety is the sensation of feeling fearful and nervous. Like depression, this is normal in certain situations. For example, an actor before going on stage or a student before an examination will feel anxious and tense. Some people seem to be always anxious but still seem to cope. Like depression, anxiety becomes an illness if it lasts long (generally more than two weeks), is interfering with the person's daily life or is causing severe symptoms.

The key features of anxiety are:
A person with anxiety will experience some of the following symptoms:

Physical
- feeling her heart is beating fast (palpitations)
- a feeling of suffocation
- dizziness
- trembling, shaking all over
- headaches
- pins and needles (or sensation of ants crawling) on her limbs or face

Feeling
• feeling as if something terrible is going to happen to her
• feeling scared

Thinking
• worrying too much about her problems or her health
• thoughts that she is going to die, lose control or go mad (these thoughts are often associated with severe physical symptoms and extreme fear)
• repeatedly thinking the same distressing thought again and again despite efforts to stop thinking them

Behaving
• avoiding situations that she is scared of, such as marketplaces or public transport
• poor sleep

Most people with a common mental disorder have a mixture of symptoms of depression and anxiety. Most never complain of feeling or thinking symptoms as their main problem but instead experience physical and behavioural symptoms.

This could be for many reasons. For example, they may feel that psychological symptoms will lead to them being labelled as 'mental' cases
Three varieties of common mental disorders may present with specific or unusual complaints:

- ✓ Panic is when anxiety occurs in severe attacks, usually lasting only a few minutes. Panic attacks typically start suddenly. They are associated with severe physical symptoms of anxiety and make sufferers feel terrified that something terrible is going to happen or that they are going to die. Panic attacks occur because people who are fearful breathe much faster than usual. This leads to changes in the blood chemistry which cause physical symptoms.

- ✓ Phobias are when a person feels scared (and often has a panic attack) only in specific situations. Common situations are crowded places such as markets and buses, closed spaces like small rooms or lifts, and in social situations such as meeting people. The person with a phobia often

- ✓ begins to avoid the situation that causes the anxiety, so that, in severe cases, the person may even stop going out of the house altogether.

- ✓ Obsessive–compulsive disorders are conditions where a person gets repeated thoughts (obsessions) or does things repeatedly (compulsions) even though the person knows these are
- ✓ unnecessary or stupid. The obsessions and compulsions can become so frequent that they affect the person's concentration and lead to depression.

3.2.7 Severe mental disorders (psychoses)

This group of mental disorders consists of three main types of illness: schizophrenia, manic–depressive disorder (also called bipolar disorder) and brief psychoses. These illnesses are rare.

However, they are characterised by marked behavioural problems and strange or unusual thinking. This is why these are the disorders most typically associated with mental illness. The majority of patients in psychiatric hospitals suffer from psychoses.

3.2.7.1Schizophrenia

Is a severe mental disorder which usually begins before the age of 30. Sufferers may become aggressive or withdrawn, may talk in an irrelevant manner and may talk to themselves. They may feel suspicious of others and believe unusual things, such as that their thoughts are being interfered with. They may experience hallucinations, such as hearing voices that others cannot. Unfortunately, many people with schizophrenia do not recognise that they are suffering from an illness and refuse to seek treatment voluntarily. Schizophrenia is often a long-term illness, lasting several months or years, and may require long-term treatment. The key features of schizophrenia are:

A person with schizophrenia will experience some of the following symptoms:

Physical

- strange complaints, such as the sensation that an animal or unusual objects are inside his body

Feeling

- depression
- a loss of interest and motivation in daily activities
- feeling scared of being harmed

Thinking
- difficulty thinking clearly
- strange thoughts, such as believing that others are trying to harm him or that his mind is being controlled by external forces (such thoughts are also called ‘delusions’)

Behaving
- withdrawal from usual activities
- restlessness, pacing about
- aggressive behaviour
- bizarre behaviour such as hoarding rubbish
- poor self-care and hygiene
- answering questions with irrelevant answers.

Imagining
- hearing voices that talk about him, particularly nasty voices (hallucinations)
- seeing things that others cannot (hallucinations).

Manic–depressive illness or bipolar disorder is typically associated with two poles (or extremes) of mood: ‘high’ mood (or mania) and ‘low’ mood (or depression). The illness usually begins in adulthood and mostly comes to the notice of the health worker because of the manic phase.
The depressed phase is similar to depression in common mental disorders except that it is usually more serious. A typical feature of this condition is that it is episodic. This means that there are periods during which sufferers are completely well, even if they are not taking treatment. This is in contrast to people with schizophrenia, who may, in the absence of medication, often remain ill.

A person with mania will experience some of the following symptoms:

Feeling
- feeling on top of the world
- feeling happy without any reason
- irritability.

Thinking
- believing that she has special powers or is a special person
- believing that others are trying to harm her
- denying that there is any illness at all

Behaving

- rapid speech
- being socially irresponsible, such as being sexually inappropriate
- being unable to relax or sit still
- sleeping less
- trying to do many things but not managing to complete anything
- refusing treatment

Imagining

- hearing voices that others cannot (often, these voices tell her that she is an important person

  An acute or brief psychosis appears similar to schizophrenia but is different in that it usually starts suddenly and is brief in duration. Thus, most sufferers recover completely within a month and do not need long-term treatment. Brief psychoses are typically caused by a sudden severe stressful event, such as the death of a loved person. Sometimes, a severe medical or brain illness can cause the psychosis; when this happens, the condition is also called ‘delirium’.

The typical symptoms seen are:

- severe behavioural disturbance such as restlessness and aggression
- hearing voices or seeing things others cannot
- bizarre beliefs
- talking nonsense
- fearful emotional state or rapidly changing emotions (from tears to laughter)

Delirium often needs urgent medical treatment.
The symptoms are similar to those of schizophrenia and mania. The key is that the symptoms begin suddenly and last less than a month.
A person with delirium will experience some of the following symptoms:

- disorientation (he does not know where he is or what time it is)
- fever, excess sweating, raised pulse rate and other physical signs
- poor memory
- disturbed sleep pattern
- visual hallucinations (seeing things others cannot)
- symptoms that vary from hour to hour, with periods of apparent recovery alternating with periods of severe symptoms.

3.2.8 Mental retardation

The term ‘mental retardation’ is being dropped by many health workers. This is because it is often used in a discriminatory way. Instead, the term ‘learning disability’ is preferred. In this manual, we will use ‘mental retardation’ because it is the most widely used and understood
term to describe the condition of delayed mental development.
Mental retardation is not a mental illness in the strict sense of the term. This is because an illness usually refers to a health problem that begins and ends. Mental retardation, on the other hand, is a state, i.e. a condition that is present from very early childhood, and remains present for the rest of the person’s life. Mental retardation means that the brain development (and thus mental abilities) of the child is slower or delayed compared with that in other children. People with mental retardation are often brought to health workers by concerned relatives for many reasons such as self-care, school difficulties and behavioural problems such as aggression.

A person with mental retardation will experience some of the following symptoms:

- delays in achieving milestones such as sitting up, walking and speaking
- difficulties in school, especially coping with studies and repeated failures
- difficulties in relating to others, especially other children of the same age
- in adolescence, inappropriate sexual behavior
- in adulthood, problems in everyday activities such as cooking, managing money, finding and staying on in a job, etc.
  There can be various degrees of mental retardation:
- mild retardation may lead only to difficulty in schooling but no other problems;
- moderate retardation may lead to failure to stay in the school system and difficulties in self-care such as bathing.
- severe retardation often means the person needs help even for simple activities such as eating.

Whereas persons with mild retardation may spend their entire lives without being referred to health workers, those at the severe end are diagnosed in early childhood because of the obvious severity of the disability. Whereas those in the mild category may be able to live alone and work in certain types of jobs, those in the severe category will almost always need close supervision and care.

3.2.9 Mental health problems in the elderly

The elderly suffer from two main types of mental illness. One is depression, which is often associated with loneliness, physical ill health, disability and poverty. This is similar to depression in other age groups. The other mental health problem in the elderly is dementia (Box 1.10). This is typically a disease of older people only.
A person with dementia (who will rarely be under the age of 60) will have some of the following symptoms:

- forgetting important things like names of friends or relatives
- losing her way in familiar areas such as in the village or home
- becoming irritable or losing her temper easily
- becoming withdrawn or appearing depressed
- laughing and crying for no reason
- having difficulty following conversations
- not knowing what day it is or where she is (disorientation)
- talking inappropriately or irrationally

3.2.10Mental health problems in children

Certain types of mental health problems that typically occur in childhood:

- dyslexia, which affects learning abilities;
- hyperactivity, where children are overactive;
- conduct disorders, in which children misbehave much more than is normal;
- depression, in which children become sad and unhappy;
- bed-wetting, in which children wet the bed at an age when they should not.

Children will also come to your attention when they have been the victims of abuse.
The main thing to remember is that these child mental health problems, unlike mental retardation, often improve, and some children completely recover. Thus, it is important not to assume that any child with a behaviour problem is mentally retarded.

The key signs that suggest mental illness in children are:

- a child who is doing badly in studies even though she has normal intelligence
- a child who is always restless and cannot pay attention

- a child who is constantly getting in trouble or fights with other children
- a child who is withdrawn and does not play or interact with other children
- a child who refuses to go to school.

3.2.11The Causes of Mental Illness

In many cultures, both medical and traditional explanations are used to understand the causes of ill health.
Traditional models are often related to spiritual or supernatural causes, such as bad Spirits or witchcraft.
You should be aware of the beliefs in your culture. However, you should also be aware of the medical theories and use these to explain mental illness to the people who consult you. It is useful to keep in mind the following main factors that can lead to mental illness:

- Stressful life events. Life is full of experiences and events. Some of these may make a person feel worried and under stress. Most people will learn how to deal with such events and carry on with life. However, sometimes they can lead to mental illness. Life events that cause great stress include unemployment, the death of a loved one, economic problems such as being in debt, loneliness, infertility, marital conflict, violence and trauma.
- Difficult family background. People who have had an unhappy childhood because of violence or emotional neglect are more likely to suffer mental illnesses such as depression and anxiety later in life.
- Brain diseases. Mental retardation, dementias and emotional problems can result from brain infections, AIDS, head injuries, epilepsy and strokes. No definite brain pathology has yet been identified for many mental illnesses. However, there is evidence to show that many illnesses are associated with changes in brain chemicals such as neurotransmitters.
- Heredity or genes. Heredity is an important factor for severe mental disorders. However, if one parent has a mental illness, the risk that the children will suffer from a mental illness is very small. This is because, like diabetes and heart disease, these disorders are also influenced by environmental factors.
- Medical problems. Physical illnesses such as kidney and liver failure can sometimes cause a severe mental disorder. Some medicines (e.g. some of those used to treat high blood pressure) can cause a depressive illness. Many medicines when used in large doses in elderly people can cause a delirium.

3.2.12 Culture and Mental Illness

There are many ways in which culture can influence mental health issues.

- Concepts about what a mental illness is differ from one culture to another. The group of disorders most often associated with mental illness is the severe mental disorders, such as schizophrenia and mania. The commonest mental health problems in general or community health care are the common mental disorders (depression and anxiety) and problems associated with alcohol and drug dependence. These disorders are rarely viewed as being mental illnesses. Although you should be aware of these mental illnesses, you need not add to the sufferer's problems by using labels with a potential stigma attached to them. Instead, you can use locally appropriate words to describe stress or emotional upset as a way of communicating the diagnosis.
- Words used to describe emotional distress. The descriptions of human emotions and illness are not easy to translate into different languages. Consider the word 'depression'. This word means sadness and is used to describe both a feeling ('I feel depressed') and an illness ('the patient is suffering from depression'). In many languages, however, while there are words to describe the feeling of sadness, there are no words that describe depression as an illness. Thus, it is important to try to understand the words in the local language that best describe depression as a feeling and as an illness. Sometimes, different words may be found for these two meanings. Sometimes, a phrase or series of words will need to be used to convey the meaning of depression as an illness.
- Beliefs about witchcraft and evil spirits. People in many societies feel that their illness has been caused by witchcraft or evil spirits or is the result of some supernatural cause. There is little to gain from challenging such views (which are often shared by the community). Such an approach will only make the person feel uncomfortable. Instead, it would be better to understand these beliefs and explain the medical theory in simple language.
- Priests, prophets and psychiatrists: what do people do when in distress? Sick people seek help from a variety of alternative, religious and traditional health care providers. Examples include: homoeopathy, Ayurveda, traditional Chinese medicine, spiritual healers, shamans, priests, pastors and prophets. This is for several reasons. First, medical health care does not have the answers for all health problems, and this is especially true for mental illness. Second, many persons associate their emotional upset with spiritual

or social factors and thus seek help from non-medical persons. Traditional treatment may help some people get better quicker than would medical treatments.

Counselling people with mental health problems.
In many Western societies, counselling to help people with emotional problems is based on psychological theories which have evolved from within their cultures. These theories are foreign to the cultural beliefs in many non- Western cultures. This does not mean that counselling therapies will not be useful in these cultures. You will need to search for resources and methods that have evolved in your own culture because these are likely to prove more acceptable.

3.2.13Promotion of Mental Health and Wellbeing – Strategies and Levels

Promotion of mental health and wellbeing is about enhancing social, emotional and mental wellbeing and quality of life. Initiatives can occur with whole populations, selected groups or individuals, and can occur in any setting. It is applicable to all people, including those people currently experiencing or recovering from a diagnosed mental illness.

Much of the mental health promotion work internationally has been conducted within the framework of the relevant activities. There are five strategies which are relevant for the whole community and specifically for people living with a diagnosed mental illness. Some examples of strategies include:

1. **Building healthy public policy** – e.g. stigma reduction, social inclusion, human rights, access to transport, crime prevention.
2. **Creating supportive environments** – e.g. anti-bullying programs in schools and workplaces, strengthening families, mentoring and peer support for young people, supported accommodation, peer support for people with mental illness, supporting people with mental illness to return to school or the workforce.
3. **Strengthening communities to take action** – e.g. community based suicide prevention, drought support in rural areas, consumer-led initiatives and consumer advocacy.
4. **Developing personal skills** – e.g. life skills training, mental health and illness literacy, parenting skills, management of emotions, workplace training.
5. **Reorienting services** to a promotion and prevention approach – e.g. services that can respond in a timely, age appropriate and culturally appropriate way.

Prevention of mental ill-health

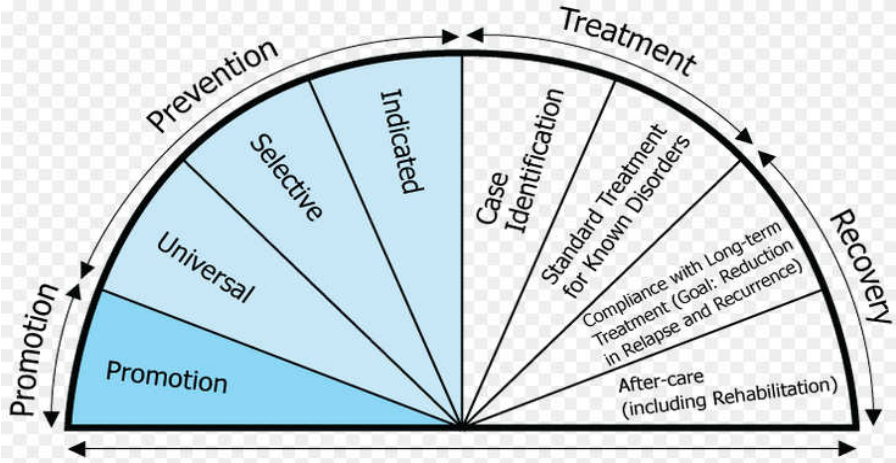

Fig. 5.4 Mental Health Prevention Spectrum
Source: www.samhsa.gov

Prevention interventions work by focusing on reducing risk factors and enhancing protective factors associated with mental ill-health. These risk and protective factors occur within the context of everyday life. They are found in: peri-natal influences; family relationships and the home; schools and workplaces; interpersonal relationships of all types; sports, art and recreation activities; media influences; social and cultural activities; the physical health of individuals; and the physical, social and economic health of communities.

Prevention initiatives are relevant to all people, regardless of their mental health status, similar to the promotion of mental health and wellbeing. The focus, however, of the intervention changes depending on whether it occurs before the onset of illness (primary prevention), during an episode of illness (secondary prevention) or after an episode of illness (tertiary prevention).

Primary prevention:

Initiatives and strategies to prevent the onset or development of mental ill-health, which may:

- Target the whole community (universal);
- Target groups known to be at higher risk (selected); or
- Target individuals at very high risk who may be showing early signs of mental ill-health (indicated).

Secondary prevention
Initiatives and strategies to lower the severity and duration of an illness through early intervention, including early detection and early treatment. These interventions can occur at any stage of life, from childhood to older age. The distinguishing feature is that intervention occurs early in the pathway to mental ill-health.

Tertiary prevention
Interventions and strategies to reduce the impact of mental ill-health on a person's life through approaches such as rehabilitation and relapse prevention. It also includes actions to ensure people have access to supports within the community, such as housing, employment and social interactions.

Early interventioncomprises interventions that are appropriate for, and specifically target, people displaying the early signs and symptoms of mental ill-health. By definition, early intervention is a form of prevention activity and overlaps both primary and secondary prevention. Interventions can be:

1. Prevention focused - targeting individuals beginning to show the early signs and symptoms of a problem (indicated primary prevention); and
2. Treatment focused - targeting individuals experiencing a first episode of mental illness (secondary prevention).

4.0 CONCLUSION

Mental illness refers to a wide range of mental health conditions — disorders that affect your mood, thinking and behavior. Examples of mental illness include depression, anxiety disorders, schizophrenia, eating disorders and addictive behaviours.

5.0 SUMMARY

- There are a number of different types of mental illnesses. Mental illness can produce severe disability and can lead to death.
- The commonest types of mental illness in the community or general health care settings are the common mental disorders, and disorders related to alcohol dependence; however, many patients and health workers may not consider these conditions as mental disorders.
- Schizophrenia, manic–depressive illness and acute psychoses are conditions that are most often recognised by the community and health workers as mental illnesses, because of the disturbed

behaviour associated with them.

- Stressful events, changes in brain function and medical factors such as brain infections are the main causes of mental illness.
- Some people may believe that spirits or supernatural factors cause mental illness. You should not challenge these beliefs but try to put forward the medical explanations for these problems.
- It is not essential that you label a person with a mental illness diagnosis. What matters is that you recognise the existence of a mental health problem, attempt to identify the type and then offer appropriate treatment.

6.0 TUTOR-MARKEDASSIGNMENT

Identify a Primary Health Care Centre around you and find out the common mental health symptoms usually presented by patients, and discuss same with your group in the discussion forum.

Conduct a serach in your culture of orientation on the effective methods of Counselling people with mental health problems and share the same with your study group.

SELF-ASSESSMENT EXCERCISE

i. Explain five strategies that can be adopted for the prevention of mental illness.
ii. Discuss the three levels of prevention of mental illness.
iii. Why should you be concerned about mental illness?
iv. Discuss the relationship between mental health and mental ill-health using the Dual ContinuaModel of Mental Health.

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UNIT 2 GENERAL SIGNS AND SYMPTOMS OF MENTAL DISORDERS

CONTENTS

1.0 INTRODUCTION

The previous unit examined the meaning, causes, types and prevention of mental illness. This unit will discuss more on the general signs and symptoms of mental illness, this will help you further in recognizing the manifestation of mental illnesses.

2.0 OBJECTIVES

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

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

3.0 MAIN CONTENT

3.1 General Signs and Symptoms of Mental Illness

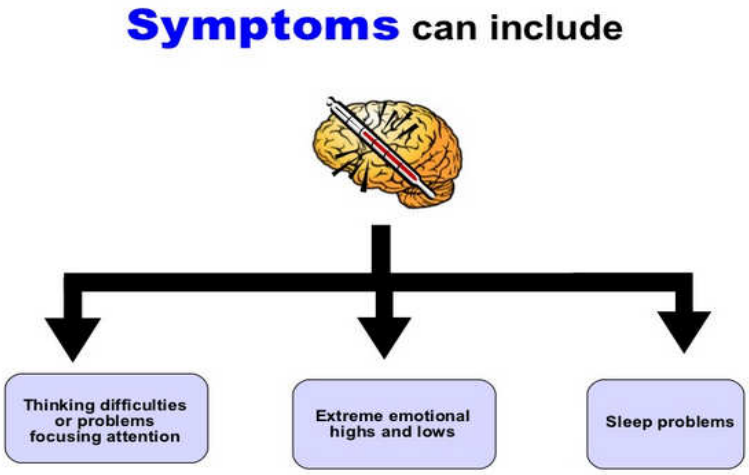

Fig. 6.1 Symptoms of Mental Illness
Source: www.slideshare.net

Mental illnesses have diverse signs and symptoms, which are grouped or clustered together to become a specific diagnosis. These groups of symptoms and signs should be persistent and intense to indicate mental illness. Examples of some clinical disorders are discussed below:

(i) Disturbances of behaviour: motor behaviour (comprises bodily movement and stream of talk).
(ii) Emotional Reaction
(iii) Delusions
(iv) Hallucinations
(v) Orientation
(vi) Disturbance of memory
(vii) Disorders of intelligence.

(i) Disturbances of Behaviour

A change in behaviour or conduct is one of the earliest symptoms very common with many psychiatric illnesses.
Motor behaviour comprises of bodily movement and stream of talk.

(a) Bodily movement

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

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

Verbigeration
Monotonous repetition of phrases

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

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

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

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

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

Flexibilitascerea
A curious "wax-like" rigidity of the muscles.

Catalepsy
Maintenance of uncomfortable postures for long periods.

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

(b) **Stream of talk Mustism**
Unwillingness to talk as seen in catatonic schizophrenia.
Flight of ideas
Patients think fast, their associations are superficial and are often guided by rhymes and distracted by change objects in the

environment (distractibility). These disturbances of thoughts and stream of talk constitute flight of ideas.

Incoherence

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

Blocking (or sudden stoppage)

Occurs in schizophrenia.

Patient breaks or stops discussion or speech.

(ii) **Emotional reaction**

The terms, mood or affects are both used to denote emotional reaction.

Elation

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

Euphoria

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

Incongruity of affect

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

Flattening of affect

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

(iii) **Delusions**

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

Types of Delusions

(a) Delusions related to depressive illnesses:

1. Self-reproach: It occurs as a result of incomplete repression and results in feelings of guilt being left behind. Patient often state he's unfit to live, to receive food, to mix with his fellow men etc.
2. Hypochondriacal: Patient is convinced that there is something wrong with his body in the absence of a physical disease. Patient may complain he has cancer, he's unable to swallow, his bowels don't open, he has tumor etc. This is manifested with involutional depression.
3. Poverty: He (patient) states he has no money; despite the fact that patient could be a millionaire before illness.

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

Ideas of unreality

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

Depersonalization

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

(b) **Delusion of grandeur** (or grandiose delusion)

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

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

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

Ideas of reference

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

Passivity feelings

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

(iv) **Hallucinations**

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

Types of Hallucination

Auditory hallucination

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

Visual hallucination

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

Hallucinations of smell and taste

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

Hallucinations of touch (Tactile)

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

Illusions

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

An example of a visual illusion is where the patient mistakes the pattern on the wall –paper for an animal.

(v) **Orientation**

Orientation is one's appreciation of time, space and personal relations at the present moment.

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

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

3.2 Observation and Examination of Psychiatric Patients

Fig. 6.2 Psychiatric-Assessment-nursing-mnemonics.
Source: http://www.nursebuff.com

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

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

(1) Behaviour and Appearance
(2) Mood or Affect
(3) Perception
(4) Thought content
(5) Intelligence level
(6) Memory
(7) Concentration
(8) Orientation – in space, time and person and by discerning abnormalities make a clinical diagnosis.

In observing /examining a psychiatric patient therefore, the students should always remember:

(a) To listen carefully.
(b) To record conscientiously.
(c) To avoid interpreting and speculating about what he supposes the patient means.

(d) To get a history from as many informants as possible.
(e) Only to use words that he understands.

i. **Behaviour and Appearance**

Appearance

Much may be observed from the patient's physical appearance: his dress, state of body hygiene and grooming. Are they appropriate to his position? The banker who comes from his office unshaven and dirty and who does not seem to recognize the inappropriateness of his appearance must be evaluated differently from the construction worker with similar appearance.
Observe facial expressions, body and limb movements and mannerisms - and note particularly how they change with the topic of conversation. Staring into space or through the examiner/observer as if preoccupied, with sudden head or body movements, may be the first hint of hallucinations.
Strange postures, stereotyped movements such as grimacing tics, apparently spontaneous emotional outbursts, rigidity of expression and physical withdrawal should be noted.

Behaviour

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

ii. **Mood or affect**

The level of and changes in feeling is a sensitive index of emotional illness. These are many possible moods: depression, elation, euphoria,
anger, suspension, fear, anxiety, panic, hostility, calm, happiness, sadness, grief and confirmation of these.
Bizarrely inappropriate moods may be observed in some patients suffering from schizophrenia, depressed patients may show a mood appropriate in direction but excessive in degree. Patients with organic brain damage may show wide fluctuations in mood in response to seemingly trivial stimulus – so called "mood liability".

iii. **Perception**

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

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

iv. Thought content

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

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

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

v. Intelligence level

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

A gross measure of the patient's intelligence can be derived from his account of his history, general knowledge and reasoning powers.
Tests of a general information should be geared to the patient's experience, interest and level of education. As with memory tests, the examiner/observer ought to develop standard questions, e.g. "Can you name the President?" Who was the President before him? What is the capital of Nigeria? etc.

vi. Memory

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

vii. Concentration

Making change mentally and serially (subtracting 7 from 100 for the simpler 4 from 25) are useful tests of concentration but the observer must make certain that inability to do mental arithmetic is not the cause of failure

or slowness. Telling the months of the year or the days of the week in reverse order are better tests of concentration for poorly educated patients.

viii. Orientation

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

ix. Insight

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

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

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

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

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

4.0 CONCLUSION

Mental illnesses have diverse signs and symptoms, which are grouped or clustered together to become a specific diagnosis. These groups of symptoms and signs should be persistent and intense to indicate mental illness.

5.0 SUMMARY

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

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

6.0 TUTOR-MARKED ASSIGNMENT

Visit the assessment unit of the psychiatric hospital close to you and observe at least ten psychiatric patients under assessment by mental health and psychiatric nurses or psychiatrist. Ask them to explain the each of the symptoms to you as presented by the patients.

SELF-ASSESSMENT EXERCISE

i. List seven general signs and symptoms discussed in this unit.
ii. What observation will you make on a client to recognize mental illness?
iii. Explain any three of the general signs and symptoms.

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UNIT 3 CLASSIFICATION OF MENTAL DISORDERS

CONTENTS

1.0 INTRODUCTION

Most of the conditions that are encountered clinically in mental health and psychiatry can be discussed under classification of mental disorders.
Classification is a process by which complex phenomena are organized into categories, classes or ranks, so as to bring together those things that must resemble each other and to separate those that differ. There are two categories of classification of mental disorders i.e. modern and old ways of classification of mental disorders. You will learn more on International Classification of mental disorders and Diagnostic Statistical Manual systems of classification of mental disorders in this unit.

2.0 OBJECTIVES

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

- explain the systems of classification of mental disorders
- name each of the five axes in the DSM
- compare key similarities and differences of the DSM and ICD.

3.0 MAIN CONTENT

3.1 Classification of Mental Disorders

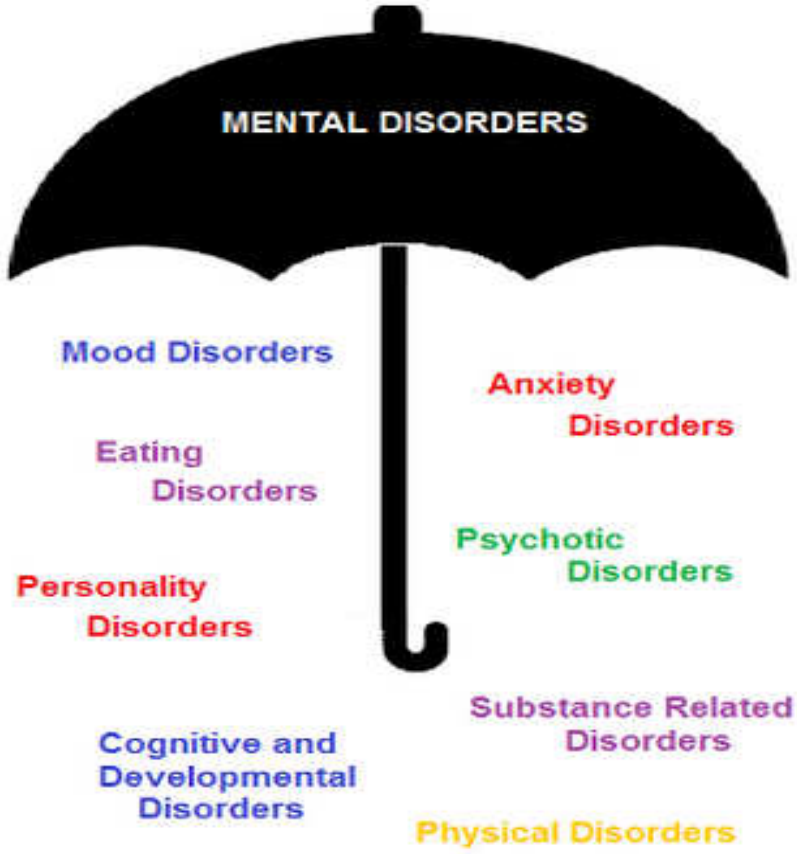

Fig. 7.1 Classification of Mental Disorders
https://www.google.com/education-portal.com

Classification is the organisation of items into groups on the basis of their common properties. There are two main approaches to classifying mental conditions and disorders:

Categorical and Dimensional both have their strengths and limitations.
Categorical approaches yes or no approach focus on deciding whether there is a presence or absence of a mental disorder either have it or not black or white - no grey areas.

A dimensional approach focuses on the extent to which a person has a disorder. Dimensional approach does not place people into diagnostic categories. It places people in dimensions (sometimes seen as dimensions of personality), diagnosis, then, becomes not a process of deciding the

presence or absence of a symptom or disorder, but rather, the degree to which particular characteristic is present.

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

3.2 Group I Classification of Psychiatric Disorders

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

1. ICD10 (International Statistical Classification of Disease and Related Health Problems) – 1992

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

F00 F09 Organic, Including Symptomatic Mental Disorders
F00 Dementia in Alzhiemer's disease
F01 Vascular dementia
F04 Organic amnestic syndrome
F05 Delirium
F06 Other mental disorders due to brain damage and dysfunction and to physical disease
F07 Personality and behavioural disorders due to brain disease, damage and dysfunction
F10 F19 Mental and Behavioural Disorders Due to Psychoactive Substance Use
F10 Mental and behavioural disorders due to use of alcohol
F11 Mental and behavioural disorders due to use of opioids
F12 Mental and behavioural disorders due to use of cannabinoids
F13 Mental and behavioural disorders due to use of sedatives or hypnotics
F14 Mental and behavioural disorders due to use of cocaine
F16 Mental and behavioural disorders due to use of hallucinoges
F20 F29 Schizophrenia, Schizotypal and Delusional Disorders
F20 Schizophrenia

F20.0 paranoid schizophrenia
F20.1 hebephrenic schizophrenia
F20.1 catatonic schizophrenia
F20.3 undifferentiated schizophrenia
F20.4 post- schizophrenic depression
F20.5 residual schizophrenia
F20.6 simple schizophrenia
F21 Schizotypal disorder
F22 Persistent delusional disorders
F23 Acute and transient psychotic disorders
F24 Induced delusional disorders
F25 chizoaffective disorders
F30 F39 Mood (Affective) Disorders
F30 Manic episode
F31 Bipolar affective disorder
F32 Depressive episode
F33 Recurrent depressive disorder
F34 Persistent mood disorder
F40-F49 Neurotic, Stress-Related and Somatoform Disorders
F40 Phobic anxiety disorders
F41 Other anxiety disorders
F42 Obsessive-compulsive disorder
F43 Reaction to severe stress and adjustment disorders
F44 Dissociative (conversion) disorders
F45 Somatoform disorders
F50-F59 Behavioural Syndromes Associated with Physiological Disturbances and Physical Factors
F50 Eating disorders
F51 Non-organic sleep disorders
F52 Sexual dysfunction, not caused by organic disorder or disease
F60-F69 Disorders of Adult Personality and Behaviour
F60 Specific personality disorders
F60.0 paranoid personality disorder
F60.1 schizoid personality disorder
F60.2 dissocial personality disorder
F60.3 emotionally unstable personality disorder
F60.4 histrionic personality disorder
F60.5 anakastic personality disorder
F60.6 anxious personality disorder
F60.7 dependent personality disorder
F61 Mixed and other personality disorders
F62 Enduring personality changes, not attributable to brain damage and disease

F63 Habit and impulse disorders
F64 Gender identity disorders
F65 Disorders of sexual preference
F70-F79 Mental Retardation
F70 Mild mental retardation
F71 Moderate mental retardation
F72 Severe mental retardation
F73 Profound mental retardation
F80-F89 Disorders of Psychological Development
F80 Specific development disorders of speech and language
F81 Specific development disorders of scholastic skills
F82 Specific development disorders of motor function
F83 Mixed specific development disorders
F84 Pervasive development disorders
F90-F98 Behavioural and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence
F90 Hyperkinetic disorders
F91 Conduct disorders
F93 Emotional disorders with onset specific to childhood
F94 Disorders of social functioning with onset specific to childhood and adolescence
F95 Tic disorders
F98 Other behavioural and emotional disorders with onset usually occurring in childhood and adolescence.
F99 Unspecified Mental Disorder

2. DSM-IV (Diagnostic and Statistical Manual of Mental disorders) – 1994

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

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

Axis i: Clinical psychiatric diagnosis
Axis ii: Personality disorder and mental retardation
Axis iii: General medical conditions
Axis iv: Psychosocial and environmental problems
Axis v: Global assessment of functioning in current and past one year

Table 7.1 Differences between ICD10 and DSMIV

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

3.3 Group II Classification of Psychiatric Disorders

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

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

Mental Subnormality (Old name, Mental Deficiency)
This term refers essentially to a subnormality of the intellect, as opposed to an abnormality in any other direction and implies that such subnormality has been present from birth to early age. In this last respect, it differs from conditions of intellectual impairment which have been acquired in later life, which can be irreversible or progressive, such as dementia.
While being in a class of their own, mental subnormal patients can manifest psychotic and neurotic symptoms and abnormalities of personality are common.

Examples of Mental Subnormality

(a) Idiot)
(b) Imbecile) Subnormal
(c) Feeble Minded)
(d) Dullness) severely subnormal

Causes

(i) Genetic basis
(ii) Biochemical abnormality
(iii) Brain damage (in many cases)
(iv) At times unknown; but will probably also turn out to have some essential organic cause.

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

Examples of Neuroses

(a) Anxiety Neurosis
(b) Obsessional Neurosis
(c) Hysterical Neurosis
(d) Phobic Neurosis

Causes

(i) Emotional conflict
(ii) Maladjustment to life situations
(iii) Genetic and constitutional factors may contribute

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

Organic psychoses
An organic mental disorder is usually considered to be the one which can be found – during life, clinical evidence of disease or damage to the brain;

or after death, demonstrable changes in cerebral structure. However, even though no structural change can be demonstrated, there are some disorders where the cause is some interference with the physical functioning of the brain.

Functional psychoses

The term "functional", however, is generally applied to conditions where the cause is not due to some known physical disorder though in such cases it cannot always be assumed that the origin is psychological in nature.
The functional psychoses can be divided into two main groups:

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

(a) The manic-depressive disorders

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

Examples of manic depressive disorders

(1) Depressive illness
(2) Manic illness
(3) Involutional melancholia (or depression)
(4) Manic-depressive illness.

(b) Schizophrenic Reaction Illness

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

Examples of Schizophrenia

(1) Simple Schizophrenia
(2) Catatonic Schizophrenia

(3) Paranoid Schizophrenia
(4) Hebephrenic Schizophrenia

Note

The term "organic mental disorder" denotes psychologic and behavioural abnormalities resulting from transient or permanent cerebral dysfunction. Organic mental disorders are distinguished from functional disorders such as Schizophrenia and affective illness in that they have known biologic causes and pathophysiologic mechanisms; whereas the functional disorders do not.

4.0 CONCLUSION

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

5.0 SUMMARY

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

You have learned the two different ways of classifying mental disorders i.e. what we can refer to as modern and old ways of classification. Hope you have had a good study.

6.0 TUTOR-MARKED ASSIGNMENT

Compare the two categories of classification systems of mental disorder in your group forum discussion and state which one is most convenient for use in clinical practice

SELF-ASSESSMENT EXERCISE

i. Differentiate between DSM and ICD classification Systems of mental disorders.
ii. Classify mental disorders according to old method of classification.

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

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MODULE 3 STRESS MANAGEMENT AND COPING MECHANISM

UNIT 1 STRESS AND STRESS MANAGEMENT

CONTENTS

1.0 INTRODUCTION

Stress is a term people often use to describe a feeling of pressure, strain, or tension. People often say that they are "under stress" or feel "stressed out" when they are dealing with challenging situations or events.

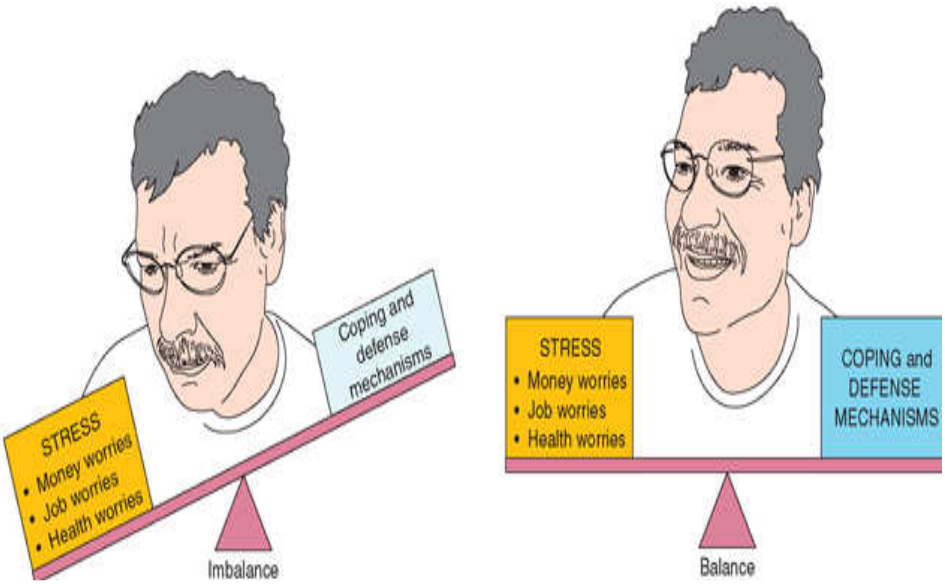
Everyone encounters stressful situations. Sometimes the stress comes from something positive (like a new job, new apartment, or new relationship) and sometimes from something negative (like having an argument with someone, or being the victim of crime).

Stress is an important factor in mental illness because it can worsen symptoms and lead to relapses. If you can decrease stress, you can decrease symptoms.

Nobody has a stress-free life and probably nobody would want to! Stress is a natural part of life. In fact, to pursue important personal goals, you need to be willing to take on new challenges, which can be stressful. Being able to cope effectively with stressful situations can minimize the effects of

stress on you and your symptoms. This can enable you to continue to pursue your goals and enjoy life.

You will learn more about the concept stress and the various ways by which the body perceives and respond to stimuli call stressor at the end of this unit.



http://what-

FIGURE 1.1 The mentally healthy person can maintain a state of emotional balance most of the time (right). If stress or change occurs (left) when-how.com/nursing/psychiatric-nursing-mental-health-nursing-part-1/

Modern life is full of hassles, deadlines, frustrations, and demands. For many people, stress is so commonplace that it has become a way of life. Stress is not always bad. In small doses, it can help you perform under pressure and motivate you to do your best. But when you are constantly running in emergency mode, your mind and body pay the price.

This module will teach you more on the concept of stress and defense mechanisms which will help you as a mental health nurse to understand while people develop mental health problems.

2.0 OBJECTIVES

At the end of this module you will be able to:

- Assist clients in managing the symptoms of stress using relevant theories and models
- Help clients apply healthy coping mechanisms to manage stressful life situations
- Define stress
- State causes of stress
- Discuss responses to stress
- Explain theories of stress
- Describe the perception of events
- Discuss the management of stress

3.0 MAIN CONTENTS

3.1 Meaning of Stress

Stress is the physical, mental and emotional human response to a particular stimulus, otherwise called as stressor. It is the adaption/coping-response that helps the body to prepare for challenging situations. Stress can be either negative or positive, depending on the stressor.

Defining stress

Strictly defined, stress is the physical, mental and emotional human response to a particular stimulus, otherwise called as stressor.
For instance, if you are to start with writing your thesis, the thesis itself is not the stimulus, rather it is the deadline, the depth of the subject, the extent of research to be done, and even your partners in your research group are just some of the many potential stimuli that can influence your response. The way you respond to these stimuli is exactly what stress is.
Stress is the mismatch between the perceived obstacle and the perceived resources for coping with the demands of the obstacle.
The stress response may be thought of as the general component common in all emotions, general adaption syndrome, where the strength of the response predetermine the strength of the emotion. Actually this also applies to positive feelings.

The two faces of stress

Stress can be negative or positive, depending on the level of our response to the stressors we encounter. Apparently, most of us only think about the bad sides of stress. Negative stress is actually about stress that is beyond one's control. This bad impact of severe stress is often manifested in physical and mental signs and symptoms.
However, when we are only exposed to mild or moderate stress, we are actually able to experience the good side of stress, which include improved creativity, learning, efficiency at work and, eventually, a higher level of self-esteem that could lead us to be able to withstand a higher stress levels in the future.

3.2 Causes of Stress

What is stressful for one person may not be the same for another, that is why the causes of stress is diverse and individualized. The most common stressors, though, include hectic work schedule, heavy work load, family and relationship problems, and financial problems.

While these popular stressors are often pointed as the culprits for stress, do you know that even positive life moments, like getting married, may also act as stressors?

As long as something demands for your efforts or pushes you to work on it, it can be called a stressor. Choosing a university to go to, getting married, selecting a car, and other great life events can be stressful for you. With all these stressors around you, you need to learn about stress management techniques in order to maintain the balance in your life.

3.3 Responses to Stress

Stress as a biological response

Hans Selye, In 1956, published the results of his research concerning the physiological response of a biological system to a change imposed on it. He gave the definition of definition of stress, "the state manifested by a specific syndrome which consists of all the nonspecifically-induced changes within a biologic system. This syndrome of symptoms has come to be known as the fight or flight syndrome.

Fig 1.2 : Fight-or-Flight Response to stress (Google image)

Selye called this general reaction of the body to stress the general adaptation syndrome. He described the reaction in three distinct stages.

General Adaptation Syndrome
The Observations by Selye

In his studies, Selye noticed that the body has been adapting to external stressors in terms of a biological pattern that is actually predictable, so that the internal balance, or homeostasis, would be restored and maintained.

In its attempt to retain homeostasis, the body makes use of its hormonal system, also known as the fight or flight response. With this response, you would notice how the body wants things to be resolved fast and easy, that's why it already resorts to releasing hormones that would enable you to combat stress in the most immediate way possible. This struggle of the body against stress is the main theme of the General Adaptation Syndrome.

Another observation that Selye discovered was that even if one's body wants to control or reduce the stress, it still has its limits. The limited supply of body's energy to adapt to the stressful environment is even more compromised when the body is exposed to the stressor continuously.

Three Phases of Stress Response

The General Adaptation Syndrome is a model that is comprised of three elements or phases which describe the body's response to stress:

1. Alarm Stage

In this phase, the initial reaction of the body to stress is that it labels the stressor as a threat or danger to balance that is why it immediately activates its fight or flight response system, and releases the stress hormones such as

adrenaline, nor adrenaline and cortisol. These hormones enable you to perform activities that you don't usually do.

For instance, when one's house is on fire, his body shifts to the alarm stage, his stress hormones released (particularly adrenaline) and then he lifts a very heavy appliance outside the burning house. But there's a catch – your blood pressure starts to rise after a minute or less, which can predispose you to damage of the brain and heart's blood vessels, putting you at risk to stroke or heart attack. The muscles you've utilized might also become painful due to tissue damage.

2. Resistance Stage

After the body has responded to the stressor, it is more likely that the stress level has been eradicated, or simply reduced. What happens next to the fight or flight response is that you body's defenses become weaker, as it needs to allocate energy to the repair of damaged muscle tissues and lower the production of the stress hormones.

Although the body has shifted to this second phase of stress response, it remains on-guard, particularly when the stressors persist and the body is required to fight them continuously, although not as stronger as it could during the initial response.

3. Exhaustion Stage

During this phase, the stress has been persistent for a longer period. The body starts to lose its ability to combat the stressors and reduce their harmful impact because the adaptive energy is all drained out. The exhaustion stage can be referred to as the gate towards burnout or stress overload, which can lead to health problems if not resolved immediately.
All in all, the General Adaptation Syndrome model by Hans Selye presents a clear biological explanation of how the body responds and adapts to stress.

Physiological Stress Response
The process of physiological stress response starts from the moment the body realizes the presence of the stressor, followed by the sending of signals to the brain, and to the specific sympathetic and hormonal responses to eliminate, reduce or cope with the stress.

The Nervous System

When your body senses that a particular stressor is present, signals about that stimulus are sent to your brain. The master gland called the hypothalamus is then alerted to arouse the Autonomic Nervous System (ANS). The ANS is the system which controls most of the major organs of your body: the heart, lungs, stomach, glands and even the blood vessels. With these organs, you'll readily notice that the ANS is responsible for the unconscious regulation of the heart beat and breathing.

The ANS is further divided into two subsystems: the Sympathetic Nervous System (SNS), and the Parasympathetic Nervous System (PNS). The PNS is responsible for the conservation of energy, as well as in defending our body by controlling gland secretions such as gastric acid, tears, saliva and mucus. It's opposite, the SNS, is the one that we can call the action system, because it is the system that is very active during a stressful situation.

Sympathetic Response

The SNS surely likes things to go very quickly when you are faced with stress. The neurotransmitter nor adrenaline is released by the nerve endings and is sent to the SNS so that the latter can:

1. **Enhance the strength of your skeletal muscles.** Have you heard news about people who were able to carry heavy furniture or equipments outside their house during fire?
   Well, fire is a very stressful situation, and thankfully we have our sympathetic response to aid us during these circumstances.
2. **Increase heart rate.** During stressful moments, your heart beats faster than it usually does so that the parts of your body which are needed to cope up with the stress would be supplied by enough oxygenated blood to remain functional until the stressful situation subsides.
3. **Shoot up sugar and fat levels.** We all know that sugar and fat provides our body with energy. During stressful situations, we need more energy to cope up, and so the SNS assists us to have more energy.

Furthermore, the SNS also:

- Enhances mental activity
- Slows down blood clotting time
- Decreases intestinal movements
- Limits digestive secretions and tears
- Dilates Pupils

- Constricts peripheral blood vessels, especially those that are not needed to cope up with the stress at hand.

Hormonal response

Other than the nervous system, the body's stress response also includes the help of the adrenal glands. Situated on top of each kidney, the adrenal glands are also included in the physiologic stress response because the adrenal medulla (the center part of the glands) has nerves that connect the gland to the SNS. The SNS stimulates the adrenal medulla to start releasing adrenaline and nor-adrenaline into the blood circulation. This action results in the "fight or flight" response, which is manifested by the increase in heart rate, dilation of bronchial airways and enhancement of the metabolic rate so more of the stored energy can be used.

Stress as an environmental event

Another concept defines stress as the "thing" or "event" that initiates the adaptive physiological and psychological responses in an individual. The event creates change in the life pattern of the individual, requires significant adjustment in lifestyle, and taxes available personal resources. The change can be either positive, such as outstanding personal achievement, or negative, such as being fired from a job. The emphasis here is on change from the existing steady state of the individual's life pattern. Positive coping mechanisms and strong social or familial support can reduce the intensity of the stressful life change and promote a more adaptive response.

Stresses as a transaction between the individual and the environment

This definition of stress expresses the relationship between the individual and the environment. Personal characteristics and the nature of the environmental event are considered. This illustration parallels the modern concept of the etiology of disease. No longer is causation viewed solely as an external entity; whether or not illness occurs depends also on the receiving organism's susceptibility. Similarly, to predict psychological stress as a reaction, the properties of the person in relation to the environment must be considered.

Precipitating Event

Lazarus and Folkman (1984) define stress as a relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well being. A precipitating event is a stimulus arising from the internal or external environment and is perceived by the individual in a specific manner. Determination that a particular person/ environment relationship is stressful depends on the individual's cognitive appraisal of the situation. Cognitive

appraisal is an individual's evaluation of the personal significance of the event or occurrence. The event "precipitates" a response on the part of the individual, and the response is influenced by the individual's perception of the event. The cognitive response consists of a primary appraisal and a secondary appraisal.

3.4 Psychological Theories of Stress

The psychological theories of stress gradually evolved from the Theory of Emotion (James-Lange), The Emergency Theory (Cannon-Bard), and to the Theory of Emotion (Schachter-Singer).

Because stress is one of the most interesting and mysterious subjects we have since the beginning of time, its study is not only limited to what happens to the body during a stressful situation, but also to what occurs in the psyche of an individual.

James-Lange Theory of Emotion
We have experiences, and as a result, our autonomic nervous system creates physiological events such as muscular tension, heart rate increases, perspiration, dryness of the mouth, etc. This theory proposes that emotions happen as a result of these, rather than being the cause of them.
Proposed by 19th century scholars William James and Carl Lange, the James-Lange Theory of Emotion presents a sequence explaining the cause-and-effect relationship between emotions and physiological events.

The Theory

Event ==> Arousal ==> Interpretation ==> Emotion
The above sequence summarizes the Theory of Emotion, a combination of concepts developed by William James, a psychologist from the United States and Carl Lange, a physiologist from Denmark. According to the theory, when an event stimulates a person (arousal), the autonomic nervous system (ANS) reacts by creating physiological manifestations such as faster heartbeat, more perspiration, increased muscular tension, and more. Once these physical events occur, the brain will interpret these reactions. The result of the brain's interpretation is an emotion. In this sense, the theory is likened to the "fight-or flight reaction, in which the bodily sensations prepare a person to react based on the brain's interpretation of the event and the physiological events.

In his statements, Lange attempted to give a simple explanation of his theory by relating its concept to the concept of common sense. He said that

our common sense tells us that if a person encounters a bear, he tends feel afraid and then he runs. According to Lange's theory, seeing a bear causes the ANS to stimulate the muscles to get tensed and the heart to beat faster. After such bodily changes, that is the time that emotion of fear emerges. It is as simple as saying that statement A, "My heart beats faster because I am afraid." is more rational than statement B, "I am afraid because my heart beats faster."Furthermore, Lange explained that statement B would just make the perception of the event a pure cognitive occurrence, and would be "destitute of emotional warmth".

Cannon-Bard Theory of Emotion

In the late 1920s, Walter Cannon and Philip Bard proposed their own theory in refutation of

the James-Lange Theory of Emotion. According to the Cannon-Bard Theory of emotion, emotions and bodily changes do not share a cause-and-effect relationship. Rather, they occur simultaneously, following a stimulating event.

Origin of the Theory

During the time of Cannon, the James-Lange theory was one of the most prominent theories of emotion. To test the theory, Cannon experimented on cats by severing the afferent nerves of the ANS' sympathetic branch. He believed that doing this would test whether emotion expression could emerge without a visceral afferent feedback (through the afferent nerves), as what the James-Lange theory implied. The results of his experiments in 1915 challenged the James-Lange theory by proposing that arousal and emotions emerge at the same time after the perception of a stimulating occurrence.

The Theory

Event ==> Simultaneous Arousal and Emotion

The above sequence summarizes the Cannon-Bard Theory of Emotion. In essence, the theory is backed up by neurobiological science. In a stimulating event, sensory signals are transmitted to the brain's relay center, the thalamus. Once the thalamus receives the signal, it relays the information to two structures: the amygdala and the brain cortex. The amygdala is responsible for the instantaneous response in the form of emotions, whereas the brain cortex is for the slower response. At the same time, the autonomic nervous system or ANS sends signals to muscles and other parts of the body, causing them to tense, increase in rate, change in rhythm, and more. Therefore, this theory views stimulation/arousal and emotion as a combined response to a stimulating event. For instance, when

a person sees a venomous snake, he feels afraid and his muscles get tensed at the same time, preparing to run away from the dangerous animal. One can observe the person's emotion based on the physiological signals that his body displays.

Schechter-Singer Theory of Emotion

Also known as the "Two-Factor Theory of Emotion", the Schachter and Singer theory of emotion is a cognitive approach to understanding how emotional states are determined by cognitive factors.

Origin of the Theory

From the late 1950s, the so-called cognitive revolution became prominent among psychologists. Following this trend, Stanley Schachter and Jerome Singer proposed that there are cognitive factors that influence the varied states of emotions, moods and feelings. They took account of the physiological-based theories such as the James-Lange Theory and the Cannon-Bard Theory, and came with a conclusion that the various visceral or physiological patterns do not match the wide variety of emotional states of individuals. The theory was formally introduced by Schachter and Singer in 1962.

The Theory

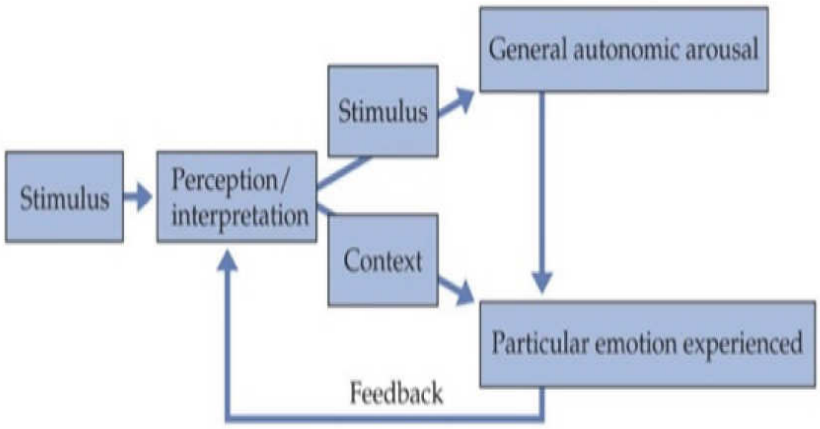


Fig. 1.3 The_Schachter-Singer_Theory_of_Emotion
Source: http://www.psychwiki.com/wiki/

The framework above shows the sequence from the stimulating event to the emergence of emotions. When an individual encounters a stimulating event, perception and interpretation of the stimulus follows. After perception and interpretation of the sensory information, the processed information is

divided into two: stimulus and the context of the event, which is a specific cognitive label. The information about the stimulus triggers a general autonomic arousal. In addition to the general autonomic arousal, the cognitive label causes a particular emotion to be experienced. Once an emotion is experienced, feedback occurs.

3.5 The Individual's Perception of the Event Stress and cognitive appraisal

The model "Theory of Cognitive Appraisal" was proposed by Lazarus and Folkman in 1984 and it explained the mental process which influence of the stressors.

According to Richard Lazarus, stress is a two-way process; it involves the production of stressors by the environment, and the response of an individual subjected to these stressors.
His conception regarding stress led to the theory of cognitive appraisal.

What is cognitive appraisal?
Lazarus stated that cognitive appraisal occurs when a person considers two major factors that majorly contribute in his response to stress. These two factors include:

1. The threatening tendency of the stress to the individual, and
2. The assessment of resources required to minimize, tolerate or eradicate the stressor and the stress it produces.

In general, cognitive appraisal is divided into two types or stages: primary and secondary appraisal.

Primary appraisal
In the stage of primary appraisal, an individual tends to ask questions like, What does this stressor and/ or situation mean? and how can it influence you? According to psychologists, the three typical answers to these questions are:

1. "this is not important"
2. "this is good"
3. "this is stressful"

To better understand primary appraisal, suppose a non-stop heavy rain suddenly pours at your place. You might think that the heavy rain is not important, since you don't have any plans of going somewhere today. Or,

you might say that the heavy rain is good, because now you don't have to wake up early and go to school since classes are suspended. Or, you might see the heavy rain as stressful because you have scheduled a group outing with your friends.

After answering these two questions, the second part of primary cognitive appraisal is to classify whether the stressor or the situation is a threat, a challenge or a harm-loss. When you see the stressor as a threat, you view it as something that will cause future harm, such as failure in exams or getting fired from job. When you look at it as a challenge, you develop a positive stress response because you expect the stressor to lead you to a higher class ranking, or a better employment.

On the other hand, seeing the stressor as a "harm-loss" means that the damage has already been experiences, such as when a person underwent a recent leg amputation, or encountered a car accident.

Secondary appraisal

Unlike in other theories where the stages usually come one after another, the secondary appraisal actually happens simultaneously with the primary appraisal. In fact, there are times that secondary appraisal becomes the cause of a primary appraisal.

Secondary appraisals involve those feelings related to dealing with the stressor or the stress it produces. Uttering statements like, "I can do it if I do my best", "I will try whether my chances of success are high or not", and "If this way fails, I can always try another method" indicates positive secondary appraisal. In contrast to these, statements like, "I can't do it; I know I will fail", "I will not do it because no one believes I can" and, "I won't try because my chances are low" indicate negative secondary appraisal.

Although primary and secondary appraisals are often a result of an encounter with a stressor, stress doesn't always happen with cognitive appraisal. One example is when a person gets involved in a sudden disaster, such as an earthquake, and he doesn't have more time to think about it, yet he still feels stressful about the situation.

Predisposing factors
A variety of elements influence how an individual perceives and responds to a stressful event. These predisposing factors strongly influence whether the response is adaptive or maladaptive. Types of predisposing factors include genetic influences, past experiences, and existing conditions.

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

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

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

Individual differences - Stress Response
There have been many studies conducted that focus on the individual differences in the stress response. According to Friedman & Rosenman, every individual belongs to either of the two types of personalty: Type A or Type B. On the other hand, Suzanne Kobasa relates "hardiness" and personality to stress response. Dr. Albert Bandura, however, introduced "selfefficacy" as an important related factor to stress response.

We all know that each of us is a unique person, and that our personalities are so vast that more mysteries of the mind are still to be studied by psychologists. Everyone has his own life experiences, which can never be exactly the same as that of another person's. While life experience is one of the major factors that affect stress response, an individual's personality, as well as hardiness and self-efficacy levels greatly influence's his or her methods on responding to stress.

Type A & Type B Personality
Famous researchers Friedman & Rosenman believed that people belong to either two basic types of behaviour or personality: Type A and Type B. According to the researchers, a person with a Type A personality is

competitive, desires to be recognized, longs for development and advancement, wants to achieve goals and therefore, tends to rush in order for him to finish the tasks assigned to him. He is typically active and alert both mentally and physically.

The person with a Type B personality is the complete opposite of the Type A person. Why? It's because the Type B personality includes the apparent lack of motivation, drive, urgency, competitive spirit, and even ambition or desire. The person with a Type B personality is described as calm, relaxed and non-competitive. A third type, Type C, is described as a personality which involves passion for work and desire to achieve goals (typical of Type A), but when faced with stress, the person becomes apathetic (typical of Type B)..

Hardiness

Another researcher, Suzanne Kobasa, initiated a study of hardiness, in which the "hardy personality" possesses the three C's: Control, Commitment, and Challenge. According to Kobasa, hardy people reflect on themselves as the managers of their environment and not the other way around. Also, she argued that hardy individuals are committed to face problems and won't stop until they find resolutions to these. In addition, hardy people view change not as a threat, but as a challenge.

In her study, Kobasa found out that hardy people rarely experience being ill compared to non-hardy individuals, which means that if a person is classified as a hardy individual, he can respond to stress in a more positive way in that his health is maintained rather than damaged.

Self Efficacy

Coined by Dr. Albert Bandura, self-efficacy refers to the sum of the internal beliefs of an individual on their capacity to influence that have an effect on his life. In relation to stress, self-efficacy refers to how you perceive yourself in terms of dealing with stressful situations.

According to psychologists, high self-efficacy levels tend to decrease negative stress feelings due to the increase in the person's sense of control of the stressful situation. On the other hand, low self-efficacy levels may result to stronger negative feelings towards the stressful experience, and ultimately to inability to cope with the stress in a positive manner.

Social Support and Stress

A network which involves an individual's family, friends and peers who are able to support the person psychologically and emotionally is called a

social support network. Psychologists say that a strong social support network leads to a better coping experience with stress.

Have you ever had a very stressful moment, and suddenly felt bold enough to face the stress all because someone tapped you on the shoulder and said the magical words, “You can do it!”?

Having a strong social support network can provide a lot of benefits to anyone, because all of us are bombarded by stress in our daily lives. Knowing what a social support network really is and how to cultivate your very own network of supportive people can do wonders in your life as you combat stress.

Defining Social Support Network

Basically, a social support network is a network of family, friends and peers who provide support in times you are faced with stressful situations. This is not like a support group that is organized by a mental health professional, though; it’s more like your group of social supporters who are present on a regular basis, and whom you can relate to even when you are not under significant stress.

Unlike a support group, your social support network isn’t formalized. You don’t have to call your friends or family members, sit on a circle and talk about the stressful moments you are enduring. Actually, your quick talk with your parents, siblings or children, your lunch break with an officemate, or your counselling with a church leader are ways wherein you breathe out your stress experience with your social support network, and strengthen your relationship with them at the same time.

Advantages of Social Support Network

Stress can be better managed when your social support network is as strong as it can be.

Here are the reasons why you should strive harder in strengthening your relationship with each identified member of your social support network:

Sense of Security

Your social support network has it all – information about your stressful situation, advice on how to manage stress, and even the silence and listening ear you need when you experience burnout. When you have them close by, you know you are secure even when stress seems to consume you.

Source of Strength
When you feel like giving up because of too much stress, your social support network is there to remind you of the abilities you possess to cope up with the stressful situation. They can personally help you with solving problems you can't handle yourself.

Feeling of Belongingness
In times of stressful moments, you may feel alone and no one is there to help you. Calling a friend, your parents, your workmate or your church mate and talking about your feelings, emotions and thoughts will make you feel a lot better and will remind you that there's always someone to comfort and support you.

Gender, Culture and Stress Response
Differences in gender and culture are found to have significant influences in how humans respond to stressors and stressful situations. These differences require a deeper understanding in order for a person to learn how he responds to stress, and whether his stress response is still healthy or not.
Personality and life experiences are truly affecting the way we respond to stress, but do you know that other factors like gender and culture can contribute to our different responses to stressors?

Gender and Stress
The ways in which stress is physically and psychologically experienced may vary because of sex difference, according to psychologists who focused their study on the relationship between gender and stress response. In 1972, Johansson & Post conducted a study which involved equal number of male and female participants. They were subjected to a particular non-stressful situation, and were then transferred to a stressful circumstance.

The results of the study showed that both male and female participants showed an increased in adrenaline levels, yet the adrenaline levels of men was much higher as compare to women. Because of this, the physiological stress response of women was lower compare to men.

Johansson & Post concluded that the results might be because of three reasons.

Men and women differ biologically in terms of hormones.
Men are typically more aggressive in physical terms than women. This was supported by Hastrup, et.al. in 1980, proving that hormonal levels truly affect stress response in women throughout their menstrual cycle.

Men and women differ in traditional gender roles, such as women are typically more gentle and caring than men. However, this assumption might have been changed over the years because women are now assuming traditionally male roles.

Culture and Stress
Learning about cultural differences also plays a vital role in understanding how each person responds to stress.

It's widely known that more black Americans suffer from coronary heart diseases than white Americans. This triggered the study of Cooper, et.al in 1999 to learn the reason behind this trend.
Together with his research team, Cooper found out that there was an unintentional genetic selection during the transfer of black Americans to the New World via slave ships. The ancestors of the black Americans today most probably survived the diarrhea outbreak during that time, which means they had a better ability to retain water which contributed to the development of Chronic Heart Disease.

Looking at today's situation, we could see that the higher unemployment and literacy rates of might have created a poverty related stress, leading more people to suffer from the consequences of negative stress response such as Chronic Heart Disease and other diseases.

In 1983, Weg initiated a study on the cultural difference between a Georgian Tribe and other cultures like the United Kingdom. He found out that the members of the Georgian tribe had a much longer life expectancy than people living in UK.

Weg concluded that there were many factors that might have contributed to the great difference between the two cultures' life expectancy rates. These include the stress-free lifestyle, fresh meat and vegetable diet, a greater social support system, higher levels of physical activity and lack of vices such as cigarette and alcohol in the Georgian tribe. It is to be studied yet whether the genes of people living in different cultures affect the stress response tendencies.

3.6 Stress Management

Stress Management is a wide variety of techniques, methods and procedures to handle stress. It has been a trending topic ever since different research studies showed the correlations between stress and the emergence,

development and progression of dreadful diseases such as cardiovascular diseases, stroke, and mental disorders.

Historical Groundwork

In order to fully understand how to manage stress, it is important to discover where the stress originates. Thus, various studies focused on the sources of stress so that the stress experience could be managed more efficiently and effectively.

Hans Selye, the author of the General Adaptation Syndrome, worked with Walter Cannon in his attempt to provide an underpinning of the scientific study of stress. From the animal studies, the two researchers extrapolated their experiments to human beings in order to identify whether the physiological responses of the animals to stressors were also exhibited by humans.

Following Selye's studies, human response to stress was also studied by Richard Rahe, one of the proponents of the Holmes and Rahe Stress Scale. Together with his co-researchers, Rahe emphasized that external stressors were the sources of stress of individuals. On the other hand, subsequent studies showed proofs that the earlier identified stressors were not the actual sources of stress. Rather, those were the internal stressors, or the manner by which the individual perceives and intends to react to the stressor.

Related Models to Stress Management

A. The Transactional Model

In 1984, Richard Lazarus and Susan Folkman proposed the Transactional Model (Cognitive
Appraisal, a model that emphasizes how stress becomes the result of the imbalance between what the situation demands and what the person possesses in relation to those demands. According to them, stress is not directly resulting from the source of the stress otherwise known as the stressors; rather, it emerges because of the individual's inability to satisfy demands. For these two researchers, therefore, stress management relates to the capacity of a person to utilize his resources in order to cope with the stress.

The Transactional Model tells us that a stress management program can only become effective if the individual's ability to eliminate, reduce, or

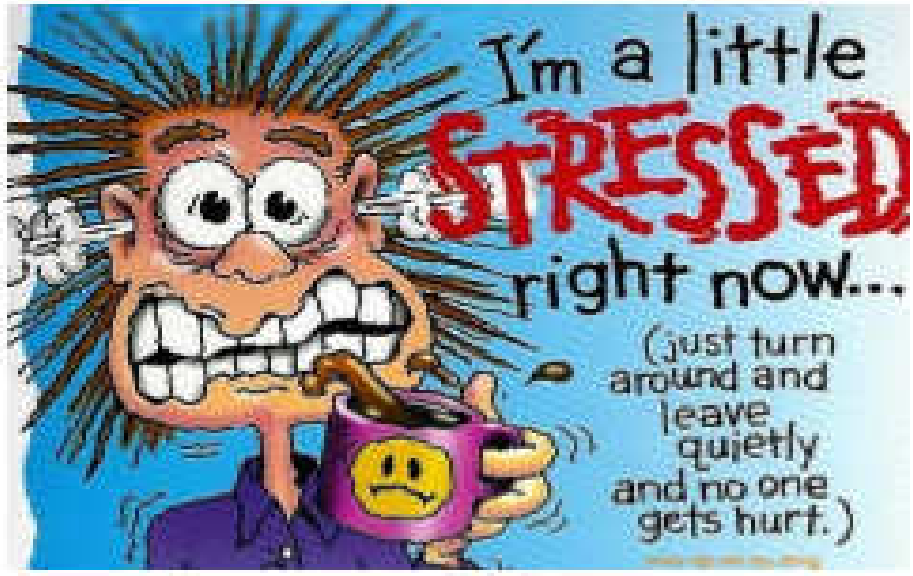
cope with stress is successful assessed, and that the factors related to such capacity are put into consideration.

B. Health Realization Model

Also called as the Innate Health Model of Stress, the Health Realization Model states that the presence of a probable stressor does not directly result to the stress experience. This idea was opposes that of the Transactional Model, because it states that the stress management program must be centered on the perception of the potential stressor by the individual, not on his appraisal of stress coping abilities.

According to this model, the appraisal must be focused on filtering one's mind of negativity an insecurity, so that he would not perceived a potential stressor as a source of stress, and would therefore lead to a more effective elimination or reduction of stress.

Stress Management Techniques



www.voiceyourself.com
Accessed Feb 7th 2010

Fig.1.4 Stress Management Techniques

More and more people have realized their need to handle stress in a more effective way, which is why it is nearly impossible to identify all the stress management techniques applied by each of us. Nevertheless, here are the mostly recognized techniques on stress management:

Exercise, Starting a New a Hobby, Meditation, Autogenic training, Artistic Expression, Fractional relaxation, Progressive relaxation, Alternative/ natural medicine, Social activity, Cognitive therapy, Conflict resolution, Deep breathing, Reading novels, Prayer, Relaxation techniques, Listening to Music and Yoga,

health.allrefer.com Accessed: Feb 7th 2010
Fig 1.5: Exercise

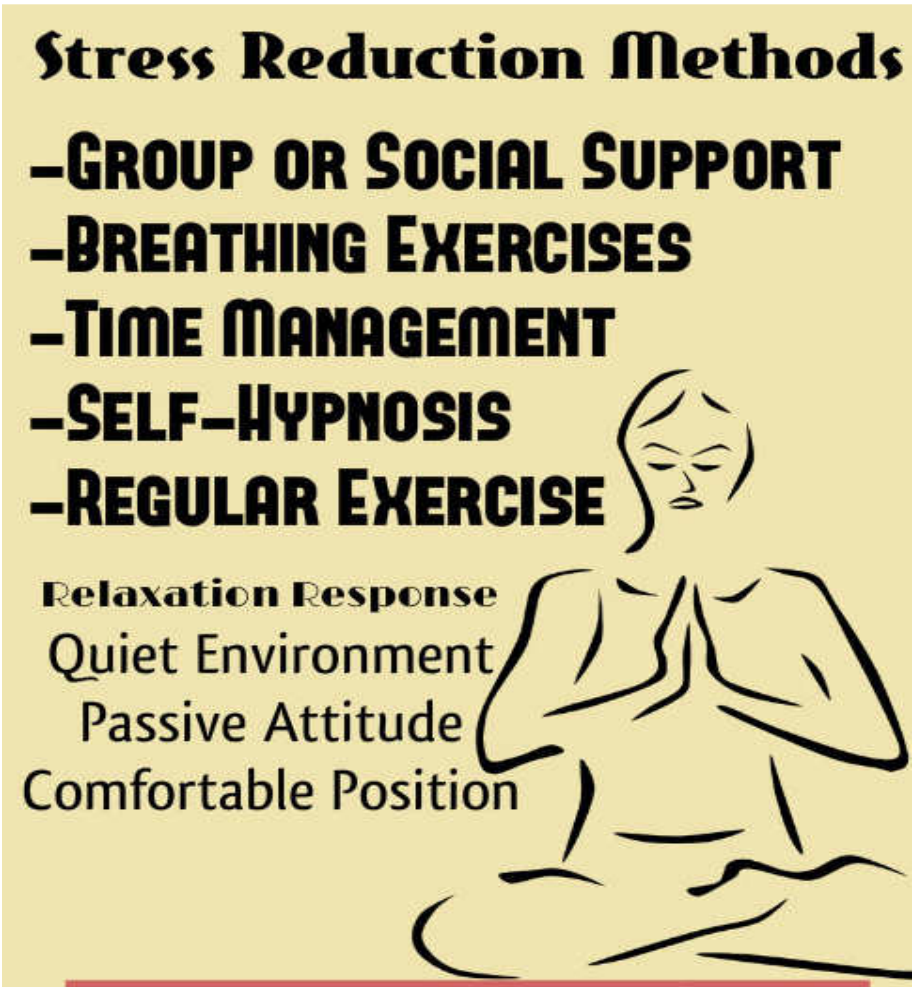


Fig. 1.6 Stress-Reduction-Methods
http://www.nursebuff.com

Traditional Stress Therapies

Stress can be managed through several traditional therapies that are proven to be effective in stress relief and recovery. Among the different traditional stress therapies, the three identified effective therapies include massage, acupuncture, and acupressure.

Massage

One of the oldest ancient healing arts, massage is founded on the principle of relaxing the body to decrease mental anxiety. India's ayurvedic tradition contains the earliest practice of massage therapy, claiming that this kind of therapy provides both physical and emotional relaxation for all individuals. Eastern civilizations have utilized massage therapy for centuries, giving rise to the famous oriental massage. For better therapeutic effects, western people modified the eastern massage methodology.

Prolonged or excessive stress often makes the body muscles over worked, causing stiffness, muscle spasms and soreness. This leads to feeling of tiredness and fatigue. In addition, lactic acid tends to accumulate further in the muscles, causing injury to skeletal muscle cells. All these and more result to feeling of exhaustion, and later decrease the energy, capacity and motivation of the person to manage the stress.

Massage is applied through the use of hands and other body parts to locate areas of high tension and relax these body areas by putting the right amount of pressure.

Many clinical studies have proven the rejuvenating effects of massage, such as the following:

- Improved blood and fluid circulation all over the body
- Increased oxygen flow
- Enhanced elimination of body wastes
- Improved muscle tone
- Feeling of relief, relaxation and peacefulness

There are different types of massage therapies to manage stress. The popular ones being Traditional Massage, Shiatsu, Reflexology, Polarity, Swedish massage, Sports Massage, Manual Lymph Drainage, Deep Tissue Massage, Rolfing and Trager..

Acupuncture

Referred to as the most common Chinese therapy, acupuncture is one of the stress therapies that relieve and control pain, a common symptom experienced by people who are exposed to constant excessive stress, especially at work.

Acupuncture rests on the principle that the body must be kept in harmony and balance through the facilitating of “life energy” in it, also called as “chi”. Stress is believed to disrupt this balance and harmony, and impedes the normal flow of chi, so acupuncture is recommended by many therapists. Acupuncture specialists insert needles into acupoints of the body in their attempt to manage the pain experienced by the person. According to them, this procedure aims to facilitate the restoration of chi distribution, allowing pain and stress relief.

To prove the effectiveness of this traditional stress therapy, the World Health Organization (WHO) conducted research and identified the following stress-related disorders as having been successfully treated by way of acupuncture:

- Headache (particularly migraine)
- Post-stroke paralysis
- Trigeminal neuralgia
- Nocturnal enuresis or bed wetting
- Meniere's disease
- Neurogenic bladder dysfunction
- Sciatica
- Irritable Bowel Disease
- Anxiety-related problems

Acupressure

Defined as the needle-less version of acupuncture, acupressure is the Chinese healing art that uses finger pressure instead of needles in facilitating the restoration of energy flow throughout the body. This is more convenient than acupuncture as it can be done wherever you are. Acupressure, although not found as effective as acupuncture, has achieved recognition for treating stress symptoms and minor stress-related disorders such as:

Body pain

- Headache and migraines
- Menstrual problems
- Sleep problems
- Anxiety-related problems
- Digestive problems

4.0 CONCLUSION

Stress is an important factor in mental illness because it can worsen symptoms and lead to relapses. If you can decrease stress, you can decrease symptoms.

5.0 SUMMARY

If you were to ask a dozen people to define stress, or explain what causes stress for them, or how stress affects them, you would likely get 12 different answers to each of these requests. The reason for this is that there is no definition of stress that everyone agrees on, what is stressful for one person may be pleasurable or have little effect on others. We all react to stress differently.

You have learnt just acquired more information on the concept of stress and how it variously affects our lives, it is is expected that after now, you should understand better how people behave differently under the same situation and circumstances.

6.0 TUTOR-MARKED ASSIGMENT

Examine a challenging situation in your academic pursuit, how does it affect your growth and your productivity and relationship with others. Discuss your experience with your friends in your activity group.

SELF ASSESSMENT

i. Explain the concept of stress as a transaction between the individual and the environment and as an environmental event.
ii. Identify and discuss the relevant psychological theories of stress.

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UNIT 2 COPING STRATEGIES AND DEFENSE MECHANISMS

CONTENTS

1.0 INTRODUCTION

Coping mechanisms can also be described as 'survival skills'. They are strategies that people use in order to deal with stresses, pain, and natural changes that we experience in life.

Coping mechanisms are learned behavioural patterns used to cope. Your have learned about the concept of stress and various ways our bodies respond to stressor in the last unit. This unit examines the ways individuals manage the stressful situations to minimize its impact on our mental health.

2.0 OBJECTIVES

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

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

3.0 MAIN CONTENT

3.1 Coping Strategies and Defense Mechanism

You will recall that we are constantly being affected by situations in our everyday life which generate various degrees of stress; some are minor and others are very serious and we react to these either consciously or unconsciously; with or without the full knowledge of what we are doing.

When we react in a conscious way to a stressful situation, we are said to be coping. In other words, we are applying a coping strategy. On the other hand when we react to a stressful situation unconsciously, we are said to be employing defense mechanism. In other words, defense mechanisms are activities or reactions, patterns, usually unconscious that protects a person from anxiety, guilt, unacceptable impulses and internal conflict.

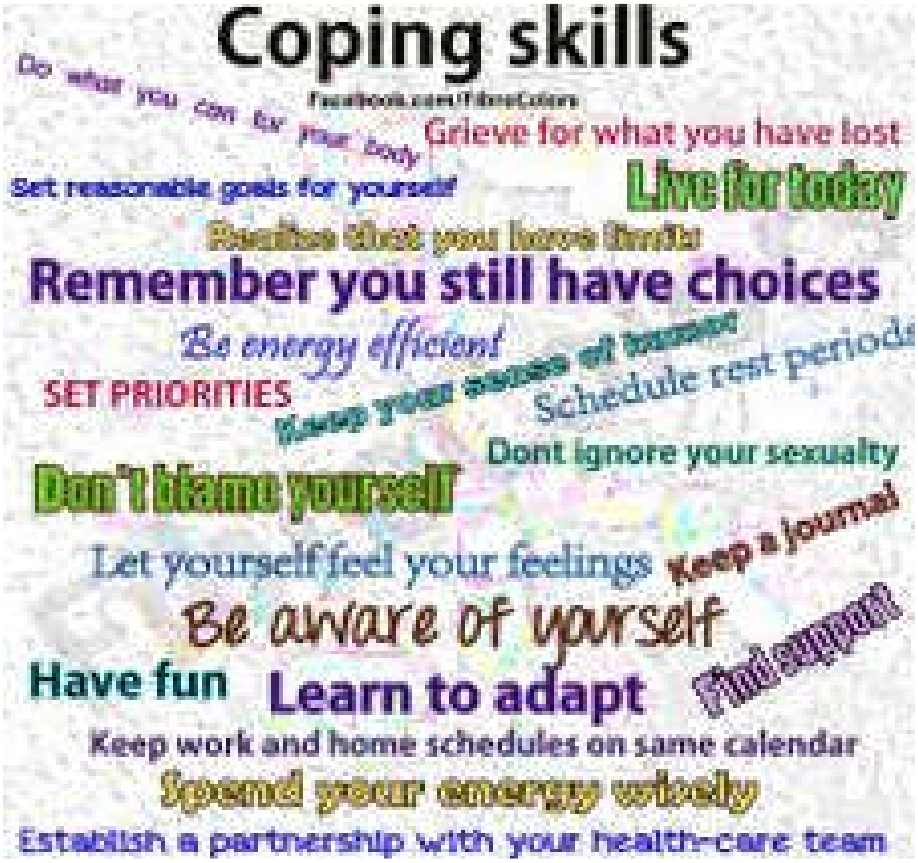

Fig. 2.1 Coping skills
www.pinterest.com

3.2 Types of Coping Strategies

There are three major types of coping strategies:

1. Less desirable coping activities.
2. Aimless and unproductive coping activities.
3. Desirable and helpful coping activities.

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

1. Over-eating

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

2. Alcohol consumption

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

3. Use of tobacco products

Some individuals when under stress resort to smoking, which they claim calms their nerves or stimulates their ability to think. This is a conscious action which does not help the person in any way whatsoever. No matter how much tobacco products one uses and in whatever form it is used, tobacco remains detrimental to human health because of the harmful effects of the chemicals – nicotine, tar and carbon monoxide on the body systems.

Some of the consequences include cancer (of the lung, oesophagus, bladder, kidney, larynx and oral cancer), bronchitis, emphysema, stroke, heart attack, cirrhosis of the liver, stomach and duodenal ulcers and other circulatory and heart diseases.

4. Drug abuse

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

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

1. Floor-pacing, hand-wringing, nail-biting, teeth-grinding, finger-tapping on an object, scratching the body and other aimless activities. These are called impulsive behaviour
2. Day dreaming which is a retreat from reality to fantasy in which a person's problems do not appear to exist or appear to have been solved. Occasional day dreaming of short duration is harmless, but it becomes dangerous when the habit is for long duration or becomes chronic, thus hampering the opportunity to face the reality of the situation.

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

1. Laughing, crying and swearing

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

a cry of joy. In other words, both sad and joyous occasions could create such tension that they are expressed in crying which invariably lets out the tension.

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

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

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

2. Talking out a problem

Talking out your problem with a close person such as your spouse, close friend, classmate, the teacher you can trust or even your religious leader or an elderly person in your family can make a lot of difference in the reduction of a problematic tension. Your listener may not have a ready solution to your problem, but you would have reduced your burden because someone now shares some of it. From talking out your problem, you may start having an insight to its solution.
Talking out a problem also includes seeking professional assistance such as a psychologist or a psychiatrist. A problem which bothers your mind is like a disease which affects your body. There should be no shame in seeking for help when you believe you have a tension which appears to linger on, and with no apparent solution.

3. Thinking through a situation

When you have been through an unpleasant experience or have been badly hurt emotionally, it is always good to give yourself a few moments of

unemotional thinking to help you put things in better perspective and to reconstruct the situation. The few moments here may imply a few hours, days or weeks. You are then in a better position after reconstructing the events to decide on an appropriate action. Rash decisions may satisfy the spur of the moment, which may in the final analysis further complicate your problem rather than solving it. For good mental health, you must cultivate the habit of thinking over a situation thoroughly before acting. It is better not to act on the spur of the moment than to regret later.

Louis E. Kopolow's Plain talk about Handling Stress" into his twelve Tips on how to cope with Stress as:

1. Try physical activity
   Vigorous exercise of any kind relieves uptight feelings and ushers in relaxation.
2. Talk out your worries
   Don't hide your worries. Ask for help when you need. For really serious problems seek professional help.
3. Know your limits
   Learn to accept what you cannot change. Don't fight a situation, if it is beyond you.
4. Don't mask your problems with hard drugs and alcohol
   Although drugs and alcohol relieve stress temporarily, they do nothing to alleviate stress conditions that caused the stress in the first place.
5. Take care of your health
   Eat well and get enough rest every day. You will be less able to deal with stressful situations if you neglect your diet and loose sleep.
6. Make time for fun
   Play is just as important to your well-being as work. It is essential to allow time for amusement and recreation.
7. Get involved with others
   When you are bored, sad and lonely, get out and go where it's all happening. Offer service to neighborhood and volunteer organizations. Help yourself by helping others.
8. Organise your time
   Don't try to do everything at once. Rank your tasks in order of importance and concentrate on the essential ones first.
9. Give in once in a while
   You don't always have to be right. Don't let other people upset you because they do not do things your way.
10. Realise that it is all right to cry

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

11. Create your own peace and quiet
    You cannot get away from your problems; try imagining a quiet country scene or a deserted beach. Escape into the pages of a good book or play some music you enjoy. Any one of these activities can induce a sense of peace and tranquility.
12. Learn how to relax
    The next time you feel tight and tense, take deep breaths. It works wonders in reducing tension. The relaxation technique titled The Relaxation Response developed by Benson in 1975 can relieve most symptoms of stress and can be used anywhere anytime.

    i. Sit quietly in a comfortable position.
    ii. Close your eyes.
    iii. Deeply relax your muscles, beginning at your feet and progressing up to your face. Keep them relaxed.
    iv. Breathe through your nose. Become aware of your breathing. As you breathe out, say the word "ONE" silently to yourself. For example, breathe IN … OUT, "ONE", etc. Breathe easily and naturally.
    v. Continue for 10 to 20 minutes. You may open your eyes to check the time, but do not use an alarm. When you finish, sit quietly for several minutes, at first with your eyes closed and later with your eyes opened. Do not stand up for a few minutes.
    vi. Do not worry whether you are successful in achieving a deep level of relaxation. Maintain a passive attitude and permit relaxation to occur at its own pace. When distracting thoughts occur, try to ignore them by not dwelling upon them and return to repeating on "ONE". Practice the technique once or twice daily, but not within two hours after any meal since the digestive processes seem to interfere with elicitation of the Relaxation Response.

3.3 Defense Mechanism

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

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

Defense mechanisms are necessary and valuable in dealing with the stressful situations we all face through life. It is most doubtful that anyone can successfully go through life without making use of some of them at one time or the other. However, reliance on them or inability to acknowledge or accept them can be a sign of low ego strength. This becomes even more difficult when we realize that most defense mechanisms are unconsciously motivated; that is, we do not know why we do them and when we do them. It requires an intelligent outsider to understand what is happening. In examining a few of the widely accepted defense mechanisms, no attempt is made to classify them as good or bad. In most cases, the value of a particular device depends on the extent to which it is used. A defense mechanism might be of great value if used in moderation and in proper situations. Yet, the same mechanism used in excess or in inappropriate situations may be very harmful. By and large, defense mechanisms are automatic responses that help one to alleviate or avoid stress rather than solving the problem which has generated it. The following are some of the more commonly used defense mechanisms found in the literature:

1. Avoidance

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

mechanism can be normal and harmless or seriously disabling depending on the degree to which it is utilized.

2. Compensation

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

3. Denial of reality

This is a defence reaction in which a person protects his ego from a stressful situation by refusing to perceive it or withdrawing from it. An example is a situation in which a motorcyclist disregards safety rules by riding without a crash helmet or a child ignores the mother's call to come home simply because he wants to play in the friend's house. Another variation is the denial of the inward feelings as in the case of a youth who might deny his feelings or desire for a girl if he knows he has no chance of winning her. The proverbial "the grapes are sour" is a good example; we also often use the same defense mechanism against objects and material things that we believe is out of our reach. We generally avoid anxiety by restricting our most cherished desire to that which is attainable or nearly so (Jones, Shainberg and Byer, 1974).

4. Displacement

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

5. Dissociation

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

6. Fantasy

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

7. Fixation

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

8. Projection

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

9. Rationalisation

This is a behaviour in which a person convinces himself that his reasons for doing something are different from what they really are; an individual explains his behaviour in such a way as to assign a socially acceptable motive to it and disguise the unacceptable motive his behaviour actually portrays. Rationalization is a commonly used defense mechanism. A good example is a student who fails a quiz but blames the teacher rather than his inadequate efforts or preparation for the quiz.

10. Regression

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

11. Repression

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

12. Sympathism

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

13. Transference

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

14. Sublimation

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

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

4.0 CONCLUSION

Coping mechanisms can also be described as 'survival skills'. They are strategies that people use in order to deal with stresses, pain, and natural changes that we experience in life.

5.0 SUMMARY

As we have seen in this unit, coping devices are methods of making necessary adaptation to stress experienced in our environment. Coping is

generally a conscious reaction to stress. The coping strategies help to reduce stress by achieving an indirect satisfaction of a need. Defense mechanisms are also a kind of adaptation or coping. They are also learned behaviour but often used unconsciously, they are common practice in everyday life.

6.0 TUTOR-MARKED ASSIGNMENT

Identify any five of the defense mechanisms you have just learned and explain how they work in the management of stressful stimuli. Submit this to your precept of at your study centre for assessment.

SELF-ASSESSMENT EXERCISE

i. What is the major difference between Sympathism and Sublimation?
ii. Defene mechanisms and coping strategies are closely related. In what ways are they similar and dissimilar?
iii. List 10 types of defense mechanisms and briefly describe five of them.

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MODULE 4 PERSONALITY AND PERSONALITY DISORDERS

UNIT 1 PERSONALITY

CONTENTS

1.0 INTRODUCTION

Personality is who we are. Our personalities determine how we act and react, as well as how we interact with and respond to the world. Despite much research, the origins of personality are still a mystery, though there are many theories that attempt to explain them. Some researchers propose that children learn personality from their parents; others believe personality is fixed from birth. Some theories address how environment, genetics, and culture influence the development of personality.

What does it mean to have “personality”? Someone with personality could be funny, passionate, daring, extroverted, aggressive, egotistical, hot-tempered, or insecure. He or she might be altruistic, humble, mellow, shy, or wary. He or she might even be all or any of these things at different times and in different places, depending on the situation. Researchers have developed many ways of assessing personality, but even if we do gain an understanding of how we are, the question of why we’re that way remains.

You will learn more on personality, personality traits and the theories of personality in this unit.

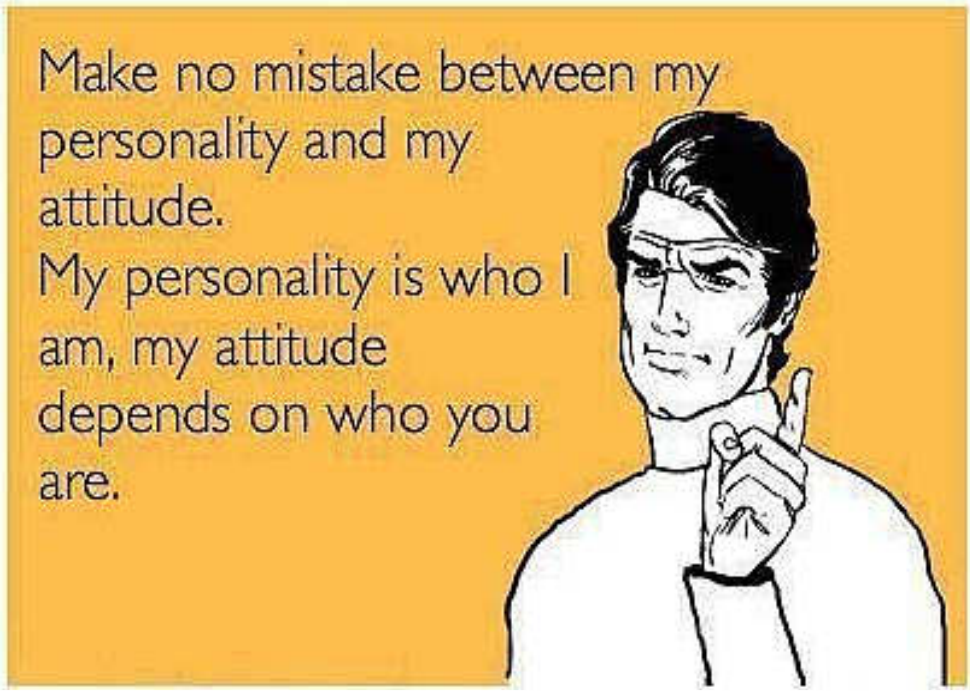

Fig. 1.1 Personality
www.barlowmccarthy.com

In some ways we are all the same. We all have the same human nature. We share a common humanity. We all have human bodies and human minds, we all have human thoughts and human feelings.

Yet in other ways we are all completely different and unique. No two people are truly alike. No two people can ever have the same experience of life, the same perspective, the same mind.
Even identical twins are unique in this respect: twin number 1 will always be twin number 1 and will never know what it is actually like to be twin number 2, to experience life and see the world through number 2's eyes.
Somewhere between these two — our common humanity and our unique individuality — lies personality.

Personality is about our different ways of being human. How we are all variations on the same themes. How the human nature we all share manifests in different styles of thinking, feeling and acting.

As a nurse, you will be dealing with different people different from you who are experiencing life situations different from your own, they will need

your help, to be able to do this successfully, you must be equipped with the knowledge of why and how there is a variation in human beings.

This module will help you acquire more knowledge on the patterns of human behaviour and the associated disorders.

2.0 OBJECTIVES

At the end of this module you will be able to:

- discuss human behavior on the basis of their personality type.
- describe the various pattern of human behavioural disorders.
- describe personality
- list the principles of personality development
- discuss various theories of personality development.

3.0 MAIN CONTENT

3.1 MEANING OF PERSONALITY

http://blog.stjohns.be
Fig. 1.2 Meaning of Personality

Personality can be defined as consistency in a person's way of being — that is, long-term consistency in their particular ways of perceiving, thinking, acting and reacting as a person. Organised patterns of thought and feeling and behaviour.

To some extent, people generally do tend to operate in a similar way day after day, year after year. We're not talking about specific actions being repeated again and again, like compulsive hand-washing, but about overall

patterns, tendencies, inclinations. Someone who has tended to be quiet and reserved up to now will probably still tend to be quiet and reserved tomorrow.

It is this general predictability in individuals' thought patterns, behaviour patterns and emotional patterns which defines personality. Or to put it another way:

"Your personality style is your organizing principle. It propels you on your life path. It epresents the orderly arrangement of all your attributes, thoughts, feelings, attitudes, behaviors, and coping mechanisms. It is the distinctive pattern of your psychological functioning—the way you think, feel, and behave—that makes you definitely you.

1.2 Normal Versus Abnormal

It is impossible to know exactly what and how another person thinks and feels. What may be adaptive in Ghana may be maladaptive in South Africa, what is humorous in Zambia may be insulting in Benin Republic, next-door neighbours may fanatically support opposing football team, or one may have no interest in sport whatsoever. Thus, the concept of "normal" must be approached with caution.

Normal is sometimes taken to mean with no impediment whatsoever. This meaning was adopted by the World health Organization when it defined health as a state of complete mental and physical well-being.

Normal may also mean average. Personality features obey the normal distribution curve, with the majority of the population registering in the middle of the graph and with a few individuals at the extremes. In the statistical sense those beyond 2 standard deviations of the mean may be regarded as abnormal with respect to the dimension under consideration (warmth, perfectionism, impulsivity).

3.3 Principle of Personality Development

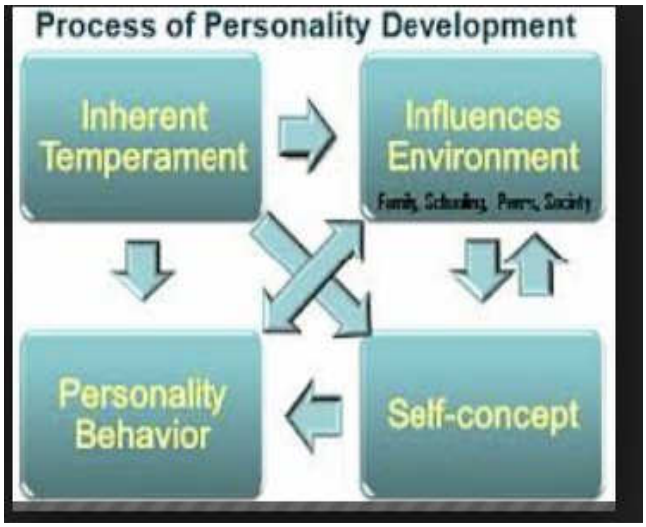

Fig. 1.3 Personality Development
www.childhealth-explanation.com

1. We all share a human nature that has been shaped by evolution and has helped humans adapt to their environment.
2. We differ from each other in dispositional traits, broad and relatively stable dimensions of personality. Humans differ in their thinking, feeling and behavior.
3. We also differ in characteristic adaptations, more situation-specific and changeable ways in which people adapt to their roles and environments, including motives, goals, plans, schemas, self-conceptions, stage-specific concerns, and coping mechanisms.
4. We differ in narrative identities, unique and integrative "life stories" that we construct about our pasts and futures to give ourselves an identity and our lives meaning.
5. Cultural and situational influences help shape all of these aspects of personality

3.4 Personality Traits

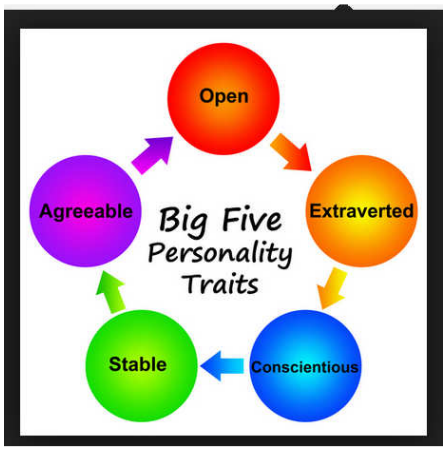

Fig. 1.4.Personality Trait
www.good.co

Personality is the collection of characteristic thoughts, feelings, and behaviors that are associated with a person. Personality traits are characteristic behaviors and feelings that are consistent and long lasting.

Traits – or descriptors used to label personality – have their origins in the ways we describe personality in everyday language.

In the early years of personality theory, many theorists used the term types to describe differences between people. Sheldon 1954, for example, categorized people according to three bodies type and related these physical differences to differences in personality. Endomorphic body types are plump and round with a tendency to be relaxed and outgoing. Mesomorphic physiques are strong and muscular, and usually energetic and assertive in personality. Ectomorphic body types are tall and thin and tend to have a fearful and restrained personality.

Not only is it unlikely that personality can be mapped to body type, but the idea that all people can be allocated to a small number of categories is challenged by modern trait theories.

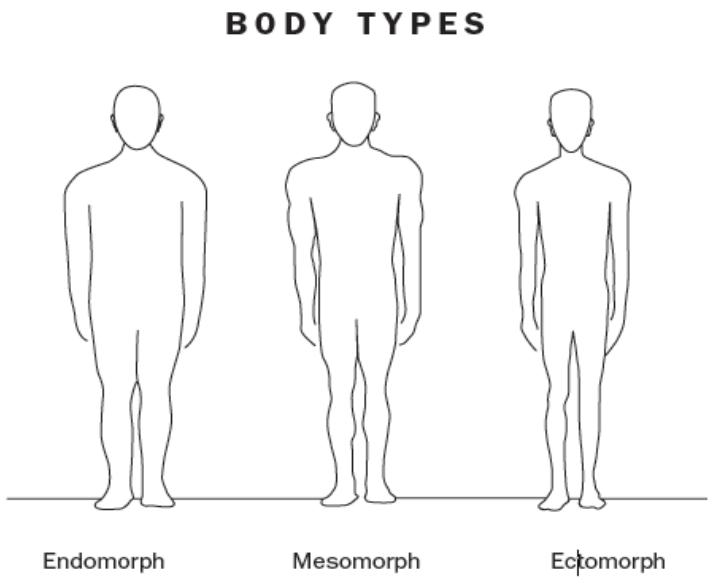

Figure 1.5 Three body types, according to Sheldon (1954).

Modern theorists view traits as continuous rather than discrete entities. So, rather than being divided into categories, people are placed on a trait continuum representing how high or low each individual is on any particular dimension. The assumption is that we all possess each of these traits to a greater or lesser degree, and that comparisons can be made between people.

For example, categorizing people into separate groups of 'sociable' versus 'unsociable' is considered to be meaningless.

Instead, it is considered more useful by trait theorists to determine the amount of sociability each person exhibits. Personality theorists regard most traits as forming a normal distribution, so some people will be very high in sociability and others very low, but most people will be somewhere in the middle.

Ancient Greek Ideas

The ancient Greeks believed that people's personalities depended on the kind of **humor**, or fluid, most prevalent in their bodies. The ancient Greeks identified four humors—blood, phlegm, black bile, and yellow bile—and categorized people's personalities to correspond as follows:

Sanguine: Blood. Cheerful and passionate.

Phlegmatic: Phlegm. Dull and unemotional.

Melancholic: Black bile. Unhappy and depressed.

Choleric: Yellow bile. Angry and hot-tempered.

The Greek theory of personality remained influential well into the eighteenth century.

Cattell's Sixteen Traits

Like the ancient Greeks, modern researchers believe in the existence of a few basic personality traits. Combinations of these basic traits, they believe, form other traits. Psychologist Raymond Cattell used a statistical procedure called **factor analysis** to identify basic personality traits from a very long list of English words that identified traits. Factor analysis allowed Cattell to cluster these traits into groups according to their similarities. He found that personality is made up of sixteen basic dimensions.

The Big Five Traits

Other researchers have since clustered personality traits into even fewer categories. Today, many psychologists believe that all personality traits derive from five basic personality traits, which are commonly referred to as the **Big Five**:

1. Neuroticism
2. Extraversion
3. Openness to experience
4. Agreeableness
5. Conscientiousness

The Big Five traits remain quite stable over the life span, particularly after the age of thirty. Although researchers identified the Big Five traits by using a list of English words, these traits seem to be applicable in many countries.

Criticisms of the Big Five Model

Critics of the Big Five have various arguments against the model:

- Some critics think that more than five traits are needed to account for the wide personality differences among people.
- Other critics argue that five traits are too many. For example, they point out that openness correlates positively with extraversion. These critics argue that just three traits— neuroticism, extraversion, and agreeableness—should be enough to fully describe personality.

- Still other critics argue that the Big Five are somewhat arbitrary because they depend on the words used in the statistical analysis that produced them. A different list of words may have yielded different basic traits.
- Some psychologists have questioned the research supporting the stability of the Big Five traits across cultures. They argue that the research could be biased because the use of Western tests is more likely to uncover cultural similarities than differences.

3.5 Theories of Personality

Psychodynamic Theories

Many psychologists have proposed theories that try to explain the origins of personality. One highly influential set of theories stems from the work of Austrian neurologist **Sigmund Freud**, who first proposed the theory of psychoanalysis. Collectively, these theories are known as **psychodynamictheories**. Although many different psychodynamic theories exist, they all emphasize unconscious motives and desires, as well as the importance of childhood experiences in shaping personality.

Sigmund Freud's Theory of Psychoanalysis

In the late 1800s and early 1900s, Freud developed a technique that he called psychoanalysis and used it to treat mental disorders. He formed his theory of psychoanalysis by observing his patients. According to psychoanalytic theory, personalities arise because of attempts to resolve conflicts between unconscious sexual and aggressive impulses and societal demands to restrain these impulses.

The Conscious, the Preconscious, and the Unconscious

Freud believed that most mental processes are unconscious. He proposed that people have three levels of awareness:

- The **conscious** contains all the information that a person is paying attention to at any given time.
  Example: The words Dan is reading, the objects in his field of vision, the sounds he can hear, and any thirst, hunger, or pain he is experiencing at the moment are all in his conscious.
- The **preconscious** contains all the information outside of a person's attention but readily available if needed.
  Example: Linda's telephone number, the make of her car, and many of her past experiences are in her preconscious.

- The **unconscious** contains thoughts, feelings, desires, and memories of which people have no awareness but that influence every aspect of their day-to-day lives.
  Example: Stan's unconscious might contain angry feelings toward his mother or a traumatic incident he experienced at age four.
  Freud believed that information in the unconscious emerges in slips of the tongue, jokes, dreams, illness symptoms, and the associations people make between ideas.

The Freudian Slip
Cathy calls up her mother on Mother's Day and says, "You're the beast, Mom," when she consciously intended to say, "You're the best, Mom." According to psychoanalytic theory, this slip of the tongue, known as a Freudian slip, reveals her unconscious anger toward her mother.

The Id, the Ego, and the Superego
Freud proposed that personalities have three components: the id, the ego, and the superego.

- **Id:** a reservoir of instinctual energy that contains biological urges such as impulses toward survival, sex, and aggression. The id is unconscious and operates according to the **pleasure principle**, the drive to achieve pleasure and avoid pain. The id is characterized by **primary process thinking**, which is illogical, irrational, and motivated by a desire for the immediate gratification of impulses.
- **Ego:** the component that manages the conflict between the id and the constraints of the real world. Some parts of the ego are unconscious, while others are preconscious or conscious. The ego operates according to the **reality principle**, the awareness that gratification of impulses has to be delayed in order to accommodate the demands of the real world. The ego is characterized by **secondary process thinking**, which is logical and rational. The ego's role is to prevent the id from gratifying its impulses in socially inappropriate ways.
- **Superego:** the moral component of personality. It contains all the moral standards learned from parents and society. The superego forces the ego to conform not only to reality but also to its ideals of morality. Hence, the superego causes people to feel guilty when they go against society's rules. Like the ego, the superego operates at all three levels of awareness.

Conflict
Freud believed that the id, the ego, and the superego are in constant conflict. He focused mainly on conflicts concerning sexual and aggressive urges because these urges are most likely to violate societal rules.

Anxiety
Internal conflicts can make a person feel anxious. In Freud's view, anxiety arises when the ego cannot adequately balance the demands of the id and the superego. The id demands gratification of its impulses, and the superego demands maintenance of its moral standards.

Defense Mechanisms
To manage these internal conflicts, people use defense mechanisms. **Defense mechanisms** are behaviors that protect people from anxiety. There are many different kinds of defense mechanisms, many of which are automatic and unconscious:

- **Repression:** keeping unpleasant thoughts, memories, and feelings shut up in the unconscious.
  Example: Nate witnessed his mother being beaten by a mugger when he was seven years old. As an adult, he does not remember this incident.
- **Reaction formation:** behaving in a way that is opposite to behavior, feelings, or thoughts that are considered unacceptable.
  Example: Lisa feels sexually attracted to her roommate's boyfriend but does not admit this to herself. Instead, she constantly makes very disparaging comments about the boyfriend and feels disgusted by the way he acts.
- **Projection:** attributing one's own unacceptable thoughts or feelings to someone else.
  Example: Mario feels angry toward his father but is not aware of it. Instead, he complains that he cannot be around his father because his father is such an angry man.
- **Rationalization:** using incorrect but self-serving explanations to justify unacceptable behavior, thoughts, or feelings.
  Example: Sylvia runs a red light while driving. She justifies this by telling herself she was already in the intersection when the light changed to red.
- **Displacement:** transferring feelings about a person or event onto someone or something else.
  Example: Seth is angry at his professor for giving him a bad grade. He leaves class and shouts angrily at a passerby who accidentally bumps into him.
- **Denial:** refusing to acknowledge something that is obvious to others.

Example: Kate's use of alcohol starts to affect her academic performance, her job, and her relationships. However, she insists that she drinks only to relieve stress and that she does not have an alcohol problem.

- **Regression:** reverting to a more immature state of psychological development.
  Example: When six-year-old Jameel gets less attention from his parents because of a new baby brother, he suddenly starts to wet his bed at night.
- **Sublimation:** channeling unacceptable thoughts and feelings into socially acceptable behavior.

Example: Priya deals with her angry feelings toward her family by writing science-fiction stories about battles between civilizations.

Psychosexual Stages of Development

Freud believed that personality solidifies during childhood, largely before age five. He proposed five stages of psychosexual development: the oral stage, the anal stage, the phallic stage, the latency stage, and the genital stage. He believed that at each stage of development, children gain sexual gratification, or sensual pleasure, from a particular part of their bodies. Each stage has special conflicts, and children's ways of managing these conflicts influence their personalities.

If a child's needs in a particular stage are gratified too much or frustrated too much, the child can become fixated at that stage of development. **Fixation** is an inability to progress normally from one stage into another. When the child becomes an adult, the fixation shows up as a tendency to focus on the needs that were over-gratified or over-frustrated.

Freud's Psychosexual Stages of Development

Stage	Age	Sources of pleasure	Result of fixation
Oral stage	Birth to roughly twelve months	Activities involving the mouth, such as sucking, biting, and chewing	Excessive smoking, overeating, or dependence on others
Anal stage	Age two, when the child is being toilet trained	Bowel movements	An overly controlling (anal-retentive) personality or an easily angered (anal-expulsive) personality
Phallic stage	Age three to five	The genitals	Guilt or anxiety about sex
Latency Stage	Age five to puberty	Sexuality is latent, or dormant, during this period	No fixations at this stage
Genital stage	Begins at puberty	The genitals; sexual urges return	No fixations at this stage

Oedipus Complex

Freud believed that the crucially important **Oedipus complex** also developed during the phallic stage. The Oedipus complex refers to a male child's sexual desire for his mother and hostility toward his father, whom he considers to be a rival for his mother's love. Freud thought that a male child who sees a naked girl for the first time believes that her penis has been cut off. The child fears that his own father will do the same to him for desiring his mother—a fear called **castration anxiety**. Because of this fear, the child represses his longing for his mother and begins to identify with his father. The child's acceptance of his father's authority results in the emergence of the superego.

During his lifetime, Freud had many followers who praised his theory, but his ideas, particularly his emphasis on children's sexuality, also drew criticism. Some of Freud's followers broke away from him because of theoretical disagreements and proposed their own theories. These theorists are called neo-Freudians. Some important neo-Freudians were Carl Jung, Alfred Adler, and object-relations theorists.

Penis Envy and Womb Envy

Freud believed that the successful resolution of the Oedipus complex played a crucial role in the formation of the superego and the personality. However, he did not have a plausible account of how this developmental phase applied to girls. Freud believed that because girls do not have a penis, they don't have the same motivation to develop a strong superego. Instead, they develop **penis envy**, or a sense of discontent and resentment resulting from their wish for a penis. This gender-biased idea has raised strong criticism from many psychologists, including the psychoanalyst Karen Horney. Horney proposed that it was more likely that men have **womb envy** because of their inability to bear children.

Carl Jung's Analytical Psychology

Until the 1910s, **Carl Jung** was a follower and close friend of Freud's. Like Freud, Jung believed that unconscious conflicts are important in shaping personality. However, he believed the unconscious has two layers: the **personal unconscious**, which resembled Freud's idea, and the **collective unconscious**, which contains universal memories of the common human past.

Jung called these common memories archetypes. **Archetypes** are images or thoughts that have the same meaning for all human beings. Jung said that archetypes exist in dreams as well as in art, literature, and religion across cultures.

Example: The archetype of the "powerful father" can be seen in the Christian conception of God, the Zeus of Greek mythology, and popular movies such as The Godfather.

Alfred Adler's Individual Psychology

Alfred Adler, another follower of Freud and a member of his inner circle, eventually broke away from Freud and developed his own school of thought, which he called **individual psychology**. Adler believed that the main motivations for human behavior are not sexual or aggressive urges but strivings for superiority. He pointed out that children naturally feel weak and inadequate in comparison to adults. This normal feeling of inferiority drives them to adapt, develop skills, and master challenges. Adler used the term **compensation** to refer to the attempt to shed normal feelings of inferiority.

However, some people suffer from an exaggerated sense of inferiority, or an **inferiority complex**, which can be due either to being spoiled or neglected by parents. Such people **overcompensate**, which means that rather than try to master challenges, they try to cover up their sense of inferiority by focusing on outward signs of superiority such as status, wealth, and power.

Object-Relations Theories

The object-relations school of psychoanalysis emerged in the 1950s, led by a group of psychoanalysts that included D. W. Winnicott and Melanie Klein. The term **object relations** refers to the relationships that people have with others, who are represented mentally as objects with certain attributes. Object-relations theorists believe that people are motivated most by attachments to others rather than by sexual and aggressive impulses. According to these theorists, the conflict between autonomy and the need for other people plays a key role in shaping personality.

Criticisms of Psychodynamic Theories

Freud's original ideas have little popularity today, but many psychologists do adhere to neo-Freudian ideas. However, other psychologists criticize psychodynamic theories for various reasons:

- Some critics argue that psychodynamic theories are not falsifiable and therefore unscientific. In response to this criticism, proponents of psychodynamic theories point out that empirical evidence does support some psychodynamic concepts. For example, empirical research shows that there are unconscious mental processes, that people have mental representations of other people, and that people

use unconscious defense mechanisms to protect themselves from unpleasant emotions such as anxiety.

- Other critics argue that psychodynamic theories are made by generalizing from a small number of patients to the whole human population. Relying only on case studies can lead to faulty conclusions.
- Still others argue that most psychodynamic theories are not based on studies that fol low people from childhood to adulthood. Instead, psychodynamic theorists listen to descriptions o f an adult patient's past and draw conclusions about the relevance of childhood experiences.

Behaviorist Theories

The school of behaviorism emerged in the 1910s, led by **John B. Watson**. Unlike psychodynamic theorists, behaviorists study only observable behavior. Their explanations of personality focus on learning. Skinner, Bandura, and Walter Mischel all proposed important behaviorist theories.

B. F. Skinner's Ideas

Learning and Conditioning of **B. F. Skinner** is well known for describing the principles of operant conditioning. Skinner believed that the environment determines behavior. According to his view, people have consistent behavior patterns because they have particular kinds of **response tendencies**. This means that over time, people learn to behave in particular ways. Behaviors that have positive consequences tend to increase, while behaviors that have negative consequences tend to decrease.

Skinner didn't think that childhood played an especially important role in shaping personality. Instead, he thought that personality develops over the whole life span. People's responses change as they encounter new situations.

Example: When Jeff was young, he lived in the suburbs. He developed a liking for fast driving because his friends enjoyed riding with him and he never got speeding tickets. After he left college, though, he moved to the city. Whenever he drove fast, he got a speeding ticket. Also, his new friends were much more cautious about driving in fast cars. Now Jeff doesn't like to drive fast and considers himself to be a cautious person.

Albert Bandura's Ideas

Albert Bandura pointed out that people learn to respond in particular ways by watching other people, who are called models. Although Bandura agrees that personality arises through learning, he believes that conditioning is not

an automatic, mechanical process. He and other theorists believe that cognitive processes like thinking and reasoning are important in learning. The kind of behaviorism they advocate is called social-cognitive learning.

Whom Do We Imitate?

Research has shown that people are more likely to imitate some models than others. People tend to imitate models they like or admire and models they consider attractive and powerful. People are also more likely to imitate models who seem similar to themselves. Furthermore, if people see models being rewarded for their behavior, they will be more likely to imitate those models. Advertisers often use these research results when they design ads. For example, ads that try to persuade young adults to purchase a certain brand of soft drink often show young, attractive models who are being rewarded with good times for their soda-drinking behavior.

Walter Mischel's Ideas

Walter Mischel, like Bandura, is a social-cognitive theorist. Mischel's research showed that situations have a strong effect on people's behavior and that people's responses to situations depend on their thoughts about the likely consequences of their behavior. Mischel's research caused considerable debate because it cast doubt on the idea of stable personality traits. Mischel himself did not want to abandon the idea of stable personality traits. He believed that researchers should pay attention to both situational and personal characteristics that influence behavior.

Today, most psychologists acknowledge that both a person's characteristics and the specific situation at hand influence how a person behaves. Personal characteristics include innate temperaments, learned habits, and beliefs. The environment includes opportunities, rewards, punishments, and chance occurrences. Personality results from a two-way interaction between a person's characteristics and the environment. This process of interaction is called **reciprocal determinism**. People's characteristics influence the kind of environment in which they find themselves. Those environments, in turn, influence and modify people's personal characteristics.

Criticisms of Behavioral Approaches

Critics of the behavioral approach to personality maintain three arguments:

- Behaviorist researchers often do animal studies of behavior and then generalize their results to human beings. Generalizing results in this way can be misleading, since humans have complex thought processes that affect behavior.
- Behaviorists often underestimate the importance of biological factors.
- By emphasizing the situational influences on personality, some social-cognitive theorists underestimate the importance of personality traits.

Humanistic Theories

Some psychologists at the time disliked psychodynamic and behaviorist explanations of personality. They felt that these theories ignored the qualities that make humans unique among animals, such as striving for self-determination and self-realization. In the 1950s, some of these psychologists began a school of psychology called humanism.

Humanistic psychologists try to see people's lives as those people would see them. They tend to have an optimistic perspective on human nature. They focus on the ability of human beings to think consciously and rationally, to control their biological urges, and to achieve their full potential. In the humanistic view, people are responsible for their lives and actions and have the freedom and will to change their attitudes and behavior. Two psychologists, Abraham Maslow and Carl Rogers, became well known for their humanistic theories.

Abraham Maslow's Theory

The highest rung on **Abraham Maslow**'s ladder of human motives is the need for **self-actualization**. Maslow said that human beings strive for self-actualization, or realization of their full potential, once they have satisfied their more basic needs.

Maslow also provided his own account of the healthy human personality. Psychodynamic theories tend to be based on clinical case studies and therefore lack accounts of healthy personalities. To come up with his account, Maslow studied exceptional historical figures, such as Abraham Lincoln and Eleanor Roosevelt, as well as some of his own contemporaries whom he thought had exceptionally good mental health.

Maslow described several characteristics that self-actualizing people share:

- Awareness and acceptance of themselves

- Openness and spontaneity
- The ability to enjoy work and see work as a mission to fulfill
- The ability to develop close friendships without being overly dependent on other people
- A good sense of humor
- The tendency to have peak experiences that are spiritually or emotionally satisfying

Carl Rogers's Person-Centered Theory

Carl Rogers, another humanistic psychologist, proposed a theory called the **person-centered theory**. Like Freud, Rogers drew on clinical case studies to come up with his theory. He also drew from the ideas of Maslow and others. In Rogers's view, the **self-concept** is the most important feature of personality, and it includes all the thoughts, feelings, and beliefs people have about themselves. Rogers believed that people are aware of their self-concepts.

Congruence and Incongruence

Rogers said that people's self-concepts often do not exactly match reality. For example, a person may consider himself to be very honest but often lies to his boss about why he is late to work. Rogers used the term **incongruence** to refer to the discrepancy between the self-concept and reality. **Congruence**, on the other hand, is a fairly accurate match between the self-concept and reality.

According to Rogers, parents promote incongruence if they give their children conditional love. If a parent accepts a child only when the child behaves a particular way, the child is likely to block out experiences that are considered unacceptable. On the other hand, if the parent shows unconditional love, the child can develop congruence. Adults whose parents provided conditional love would continue in adulthood to distort their experiences in order to feel accepted.

Results of Incongruence

Rogers thought that people experience anxiety when their self-concepts are threatened. To protect themselves from anxiety, people distort their experiences so that they can hold on to their self-concept. People who have a high degree of incongruence are likely to feel very anxious because reality continually threatens their self-concepts.

Example: Erin believes she is a very generous person, although she is often stingy with her money and usually leaves small tips or no tips at restaurants. When a dining companion comments on her tipping behavior,

she insists that the tips she leaves are proportional to the service she gets. By attributing her tipping behavior to bad service, she can avoid anxiety and maintain her self-concept of being generous.

Criticisms of Humanistic Theories

Humanistic theories have had a significant influence on psychology as well as pop culture. Many psychologists now accept the idea that when it comes to personality, people's subjective experiences have more weight than objective reality. Humanistic psychologists' focus on healthy people, rather than troubled people, has also been a particularly useful contribution.

However, critics of humanistic theories maintain several arguments:

- Humanistic theories are too naïvely optimistic and fail to provide insight into the evil side of human nature.
- Humanistic theories, like psychodynamic theories, cannot be easily tested.
- Many concepts in humanistic psychology, like that of the self-actualized person, are vague and subjective. Some critics argue that this concept may reflect Maslow's own values and ideals.
- Humanistic psychology is biased toward individualistic values.

  Biological Approaches

  Psychologists agree that environmental factors interact with genetic factors to form personality. Some psychologists have proposed theories that emphasize these genetic influences on personality.

Hans Eysenck's Theory

Psychologist **Hans Eysenck** believes that genetics are the primary determinate of personality, although he thinks conditioning also plays a role. According to Eysenck, personality traits are hierarchical, with a few basic traits giving rise to a large array of more superficial traits. Genetically determined differences in physiological functioning make some people more vulnerable to behavioral conditioning. Eysenck suggests that introverted people have higher levels of physiological arousal, which allows them to be conditioned by environmental stimuli more easily. Because of this, such people develop more inhibitions, which make them more shy and uneasy in social situations.

Empirical evidence for genetic contributions to personality comes mainly from two kinds of studies: studies of children's temperaments and heritability studies.

Studies of Temperament

Temperament refers to innate personality features or dispositions. Babies show particular temperaments soon after birth. Temperaments that researchers have studied include reactivity, which refers to a baby's excitability or responsiveness, and soothability, which refers to the ease or difficulty of calming an upset baby.

Researchers have studied children from infancy to adolescence and found that temperaments remain fairly stable over time. However, temperaments can also be modified over time by environmental factors.

Heritability Studies

Heritability studies also provide evidence for genetic contributions to personality. **Heritability** is a mathematical estimate that indicates how much of a trait's variation in a population can be attributed to genes.

Twin studies help researchers to determine heritability, "Evolution and Genes." Researchers have shown that identical twins raised together are more similar than fraternal twins raised together in traits such as positive emotionality, negative emotionality, and constraint. Identical twins separated early in life and raised apart are more similar in these traits than are fraternal twins raised together. Both of these research findings suggest the existence of a genetic component to personality.

Behavioral geneticists have shown, after doing studies in many different countries that the heritability of personality traits is around .5, which means that 50 percent of the variation in personality traits in a group of people can be attributed to genetic differences among those people.

The Influence of Family Environment

Surprisingly, research shows that sharing a family environment doesn't lead to many similarities in personality. There is no or little correlation between the personality traits of adopted children and their adoptive parents. Researchers think this is because parents don't act the same way with all their children. Children's temperaments influence how a parent behaves toward them, and a child's gender and place in a birth order can also affect how that child is treated.

Environmental Influences

The environment also has important influences on personality. These include peer relationships and the kinds of situations a child encounters. The interactions between innate characteristics and environmental factors are two-way. Children's temperaments are likely to influence their peer relationships and the situations they encounter. Similarly, peers and situations can modify children's personality characteristics.

Evolutionary Approaches

Evolutionary theorists explain personality in terms of its adaptive value. Theorists such as David Buss have argued that the Big Five personality traits are universally important because these traits have given humans a reproductive advantage.

Culture and Personality

Cultural psychologists have noted that some aspects of personality differ across cultural groups. For example, Americans and Asians have slightly different conceptions of self. American culture promotes a view of the self as independent. American children tend to describe themselves in terms of personal attributes, values, and achievements and they learn to be self-reliant, to compete with others, and to value their uniqueness.

Many Asian cultures, such as those of Japan and China, promote a view of the self as interdependent. Children from these cultures tend to describe themselves in terms of which groups they belong to. They learn to rely on others, to be modest about achievements, and to fit into groups.

Researchers believe that culture influences aggressiveness in males. In places where there are plentiful resources and no serious threats to survival, such as Tahiti or Sudest Island near New Guinea, males are not socialized to be aggressive. Culture also influences altruism. Research shows that children tend to offer support or unselfish suggestions more frequently in cultures where they are expected to help with chores such as food preparation and caring for younger siblings.

Challenges for Cultural Psychology

Cultural psychologists face the difficult challenge of studying and describing differences among cultures without stereotyping any particular culture. Ideally, cultural psychologists acknowledge that all members of a culture don't behave similarly. Variation exists within every culture, in terms of both individuals and subcultures. Cultural psychologists also try not to exaggerate differences among cultures.

4.0 CONCLUSION

Personality is who we are. Our personalities determine how we act and react, as well as how we interact with and respond to the world. Despite

much research, the origins of personality are still a mystery, though there are many theories that attempt to explain them. Some researchers propose that children learn personality from their parents; others believe personality is fixed from birth. Some theories address how environment, genetics, and culture influence the development of personality.

5.0 SUMMARY

When you characterize yourself as thoughtful, intelligent, and ambitious, you are describing features of your personalities. In this unit you have learned more about the meaning, theories and traits of personality which will help your better in understanding the nature of human behavior.

6.0 TUTOR-MARKED ASSIGNMENT

Based on what you have just learned in this unit, describe two of your friends with their personality traits, and share with your colleagues in your discussion forum.

SELF-ASSESSMENT EXERCISE

i. What are the Big Five traits?
ii. What are psychodynamic theories?
iii. In Freud's view, what causes anxiety?
iv. Describe Maslow's self-actualizing personality.

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UNIT 2 PERSONALITY DISORDERS

CONTENTS

1.0 INTRODUCTION

Personality disorder depends on indefinite conceptual issues. The following pages attempt a practical approach. In most textbooks of psychiatry the personality disorders appear just before the index. They are shoved to the back, and many students assume the personality disorders lack importance.

On the contrary, personality disorders are important from the perspective of both prevalence and consequence. People with personality disorder constitute up to 20% of the general population, at least 15% of psychiatric outpatients, and at least 10% of psychiatric inpatients.

Students encounter people with personality disorder more frequently than these prevalence figures might suggest. People with personality disorders are frequent attendees at public hospital Emergency Departments, as a result of social crises, injuries from fights, alcohol or drug intoxication or with self-injuries. People with personality disorders are often encountered as inpatients following over-doses and because of they have difficulty managing any other chronic disorder which they may suffer.

Co-morbid personality disorder makes the management of other psychiatric disorders such as schizophrenia and bipolar disorder more problematic. Thus, while only 10% of the inpatients of public hospital psychiatric units have personality disorder as their primary disorder, many other psychiatric patients will be co-morbid for personality disorder.

This unit will increase your knowledge on types and pattern of personality disorders which are the basis of mental disorders.

2.0 OBJECTIVES

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

- identify personality trait disturbances
- explain the personality pattern disturbances
- discuss the management of personality disturbances

3.0 MAIN CONTENT

3.1 Personality Disorder

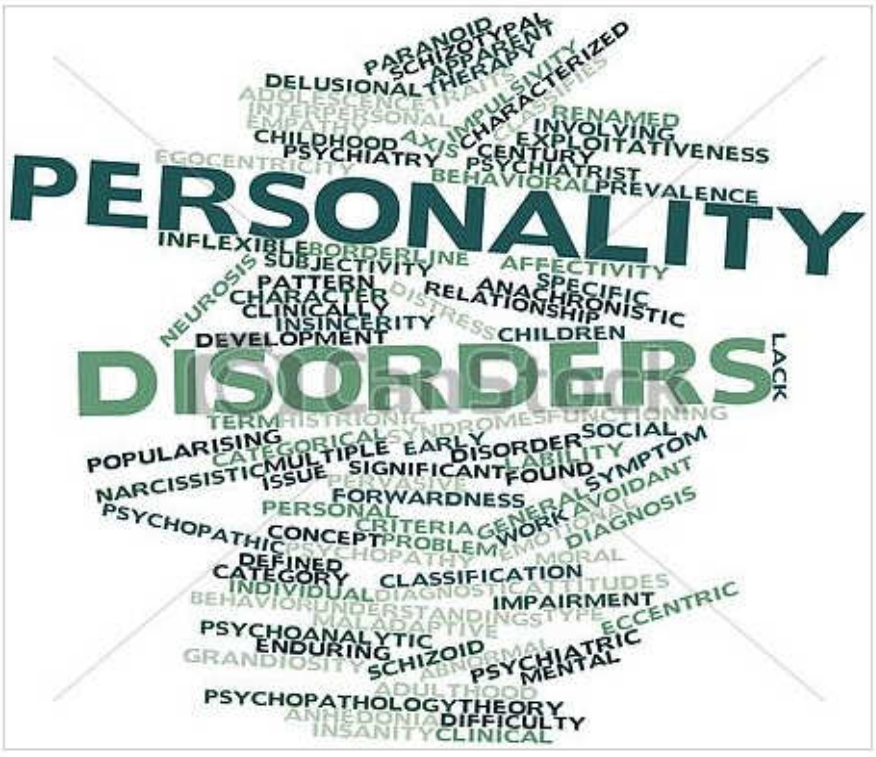

Fig. 2.1 Personality Disorder
http://www.canstockphoto.com/word-cloud-for-personality-disorders

"A Personality disorder is an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress and impairment" (DSM-IV-TR).

Exactly how the "distress and impairment" is to manifest is not clear. People with "neurotic disorders" (an old fashioned term, an example is anxiety disorder) have "autoplastic defences" meaning they react to stress by changing their internal psychological process, and perceive their disorder as "ego-dystonic" meaning they find their symptoms unacceptable, objectionable and needing to be changed. People with personality disorders, in contrast, have "alloplastic defences" meaning they react to stress by attempting to change the external environment (rather than themselves), and perceive their symptoms (personality deficits) as "ego-syntonic" meaning they find these aspect of themselves to be acceptable, unobjectionable and not in need of change.

As people with personality disorder believe the world should change to accommodate them (rather than they adjust to the world) and view their own features as being acceptable and not in need of change, they experience less distress as a direct result of their personality disorder than might be expected. However, the world does not change to suit them, and they experience much indirect distress as a result of their personality disorder; that is, their maladaptive responses lead to failed relationships (with lovers, family and employers), losses and disappointments. These are the cause of great distress.

Some authorities have observed that the individual with personality disorder (particularly, antisocial personality disorder) generate distress in others, irrespective of whether they experience distress themselves. This feature is not included in the DSM-IV definition. The failure of the relationships and conflicts experienced by people with personality disorder inevitably involve others, and naturally generate distress in others.

The DSM-IV definition of personality disorder makes the point that the behaviour of the individual is "inflexible". It does not make the important point that the individual with a personality has a limited repertoire, or number of ways of responding. Faced with opposition the normal/average individual has a range of responses: to think of a new approach, work harder and try again when better prepared, to use humour, to be more assertive, to reassess whether the goal is worth further effort or not, etc. The individual with a personality disorder has a limited number of ways of

responding (for example, may be largely limited to seduction or aggression). These are applied in all situations, and because of the inflexibility of the individual, they are applied repeatedly, even when they have already proved unsuccessful. In these circumstances loss and disappointment, and direct and indirect distress are inevitable.

Cloninger et al, in 1993, described his Temperament and Character Inventory (TCI) – an important contribution to the study of personality. Self-determination and co- operativeness are 2 of the 7 TCI factors. High scores indicate a strong sense of responsibility (self-determination) and agreeableness (co-operativeness). They claimed that low scores indicate the propensity to blame others (low self- determination) and self-centeredness (low co-operativeness), and personality disorder.

3.2 Dimensional Model and Assessment Method

The view that we all share the same personality structure and that our personality features (traits) can be registered on various continua is the theoretical basis of the dimensional models of personality/personality disorder.

The main problem has been to identify and describe the dimensions which define personality and to establish whether these dimensions are universal.

The Eysenck Personality Inventory (EPI) measures two separate dimensions: extraversion-introversion (which measures reserved versus outgoing attitude) and neuroticism (which measures emotional lability). The Cattell 16 Personality factor Test (16PF) measures 16 different dimensions, and the Minnesota Multiphasic Personality Inventory (MMPI) (probably the most widely used test of personality) measures 10 different dimensions.

Zuckerman et al in 1964, described a sensation-seeking scale (SSS), aspects of which were incorporated into subsequent comprehensive personality tests.
McCrae & John in 1992, developed a five-factor model (FFM) of personality which has been widely accepted. It employs the personality dimensions of, openness, conscientiousness, extraversion, agreeableness, and neuroticism, known by the acronym OCEAN.

Cloninger et al, attempted to overcome the division between the dimensional and the categorical models. They described four temperamental dimensions (novelty- seeking, harm avoidance, reward

dependence, and persistence), which are present from birth and are stable, and three character dimensions (self-direction, co-operation, and self-transcendency) which are variable and modified by experience. They consider that while the temperamental dimensions strongly influence behaviour, it is the character dimensions which determine the presence or absence of personality disorder. In particular, Cloninger et al, find that low scores on self-direction and co-operation are strongly associated with personality disorder.

Opponents of the questionnaire approach to personality assessment claim these instruments have no ability to objectively assess the individual's capacity for effort, stress tolerance, physical violence, enduring relationships, or the individual's "likableness".

Categorical model and assessment method
The categorical model is used in the DSM-IV and ICD-10. It considers the personality categories to be discontinuous.

Many theories recommended dimensional approach, and this remains the focus of students of normal personality. However, for clinical purposes and the diagnosis of personality disorder, the categorical diagnostic system is the dominant method, and is likely to remain so in the foreseeable future.

Given the existing categorical diagnostic system, and the limitations of the dimensional models, the clinical interview with the patient and those who know the patient well is currently the most useful diagnostic method. As personality determines the adjustment to the environment, a detailed life history provides extensive information regarding personality and likely future responses. The clinical interview is also a test situation, providing practical, real-time examples of the patient's manner of self-presentation and response. The skilled interviewer will also make observations regarding the interviewer's own response to the patient, which is likely to be similar to the responses of others.

3.3 Personality Disorder as a Mental Disorder

There has been a view (not now widely held) that the personality disorders are not like the other mental disorders, and even, that they should not be considered to be mental disorders at all. The underpinning of this view included that personality features can be located on a continuum with no clear demarcation between normal and abnormal. Analogies were drawn with skin colour and height. Also, psychiatric disorders such as Alzheimer's disease and to a lesser extent, schizophrenia and bipolar

disorder were associated with brain pathology (albeit only a group basis), but this had not been shown for personality disorder.

Related confusion arose when the DSM placed disorders such as Alzheimer's disease, schizophrenia and bipolar disorder on Axis I, and personality disorders on Axis II.
A full exploration of this topic calls for discussion of the concepts of disease, sickness, illness, disorder, deviance, acquired disorders and developmental problems, and the role and legitimate responsibilities of doctors (and other health professionals). Instead, let us be satisfied with the pragmatism of the DSM-IV.

Mental disorder.
The DSM-IV admits that "no definition adequately specifies precise boundaries of the concept of mental disorder". However, due to imperative for a definition, the following statement was achieved, "In DSM-IV, each of the mental disorders is conceptualized as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom". Acceptance of such definitions has been universal, and accordingly, personality disorders can be considered mental disorders and the legitimate target of doctors and other health professionals.

The explanation of why the mental disorders appear in DSM-IV on two separate axes is also pragmatic. It is stated that this arrangement is to ensure that personality disorders are no overlooked. The so-called Axis I disorders are "usually more florid" and may obscure important aspects of personality. The DSM-IV continues, "The coding of Personality Disorders on Axis II should not be taken to imply that their pathogenesis or range of appropriate treatment is fundamentally different from that for the disorders coded on Axis I".

3.4 Diagnostic Criteria

Table 2.1 Clusters of personality disorder, adapted from DSM-IV-TR (American Psychiatric Association, 2000)

Cluster		Subtype	Discriminating features
A	Odd/eccentric	Paranoid	Suspicious
		Schizoid	Socially indifferent
		Schizotypal	Eccentric
B	Erratic/impulsive	Antisocial	Disagreeable

		Borderline	Unstable
		Histrionic	Attention seeking
		Narcissistic	Self-cantered
C	Anxious/fearful	Avoidant	Inhibited
		Dependent	Submissive
		Obsessive	Perfectionistic

DSM-IV groups the personality disorders into three clusters, based on descriptive similarities (Table)

The student should at first identify the appropriate Cluster. The precise diagnosis is less important. DSM-IV criteria are of each personality disorder listed below.

Students will have greatest exposure to people with Cluster B personality disorder, as they are far more likely than those in Cluster A and C to present at Emergency Departments and to be admitted to public hospitals.

Cluster A – Individuals appear odd or eccentric

Paranoid
Pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts.
There must be at least 4 of the following:

- Suspects, without sufficient basis, that others are exploiting, harming, or deceiving
- Preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates
- Reluctance to confide in others
- Reads hidden demeaning or threatening meanings into benign remarks
- Persistently bears grudges (unforgiving of insults or slights)
- Perceives attacks on his/her character or reputation which are not perceived by others
- Recurrent unjustified suspicions regarding fidelity of spouse or partners

Prevalence rate in the general population is 0.25-0.5%. Prevalence rate in psychiatric inpatient units is 10-30%. Increased prevalence in the families of people with schizophrenia and delusional disorder.

Schizoid
There is a pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts.

There must be at least four of the following:

- Indifference to praise or criticism
- Preference for solitary activities and fantasy
- Lack of interest in sexual interactions
- Lack of desire or pleasure in close relationships
- Emotional coldness, detachment, or flattened affectivity
- No close friends or confidants other than family members
- Pleasure experienced in few, if any, activities

Prevalence estimates in the general population vary, may be as high as 7.5%. Increased prevalence in the families of people with schizophrenia

Schizotypal
There is a pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behaviour, beginning by early adulthood and present in a variety of contexts. There must be at least 5 of the following:

- Ideas of reference (not delusions)
- Odd beliefs and magical thinking (superstitiousness, beliefs in clairvoyance, telepathy, etc)
- Unusual perceptual disturbance (illusions, sensing the presence of nearby people etc)
- Paranoid ideation and suspiciousness
- Odd, eccentric, peculiar behaviour
- Lack of close friends, except family members
- Odd thinking and speech without incoherence (vague, metaphorical etc)
- Inappropriate or constricted affect
- Social anxiety that does not diminish with familiarity and that is associated with paranoid fears. Prevalence rate in the general population is 3%. Increased prevalence in the families of people with schizophrenia.

Cluster B – Individuals appear erratic or impulsive

Antisocial
There is a pervasive pattern of disregard for and violation of the rights of others occurring since the age of 15 years. The individual must be at least 18 years of age and there must be evidence of conduct disorder before 15 years of age.

There must be at least 3 of the following:

- Failure to conform to social norms (resulting in frequent arrests)
- Deceitfulness, including lying and conning others for personal profit/pleasure
- Recklessness, with disregard for the safety of self or others
- Irresponsibility, failure to honour financial obligations or sustain work
- Lack of remorse, indifference or rationalization of having hurt, mistreated or stolen from others A feature of antisocial personality disorder, which is not specifically mentioned in the DSM-IV criteria, is low impulse control, or "impulsivity". Low impulse control can lead to inappropriate aggression or other unacceptable behaviour .

Prevalence rate in the general population is 3% for men and 1% for women. Increased prevalence in the families of people with antisocial personality disorder.

In the past, the terms antisocial personality and psychopath/psychopathic personality disorder were used interchangeably. The modern approach, however, makes a distinction. The antisocial individual is one who demonstrates antisocial behaviour of the type listed above. The psychopathic individual demonstrates antisocial behaviour, but in addition, demonstrates emotional impairment such as lack of guilt. Only 1/3 of those with antisocial behaviour meet the criteria for psychopathy (Hart & Hare, 1996). It is argued that the emotional impairment of individuals with psychopathy interferes with socialization such that they do not learn to avoid antisocial behaviour.

Borderline
A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts. There must be at least 5 of the following:

- Frantic efforts to avoid real or imagined abandonment
- A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
- Identity disturbance: markedly and persistently unstable self-image or sense of self
- Impulsivity in al least 2 areas that are potentially self-demanding (eg, spending, sex, substance abuse, reckless driving, binge eating)
- Recurrent suicidal behaviour, gestures or threats, or self-mutilation behaviour
- Affective instability due to a marked reactivity of mood (eg, intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days) • Chronic feeling of emptiness
- Inappropriate, intense anger or difficulty controlling anger (eg, frequent displays of temper, constant anger, recurrent physical fights)
- Transient, stress-related paranoid ideation or severe dissociative symptoms.

Prevalence rates are 2% in the general population, and 20% in psychiatric inpatient populations. Childhood abuse is frequently reported. There is an increased prevalence in the families of people with borderline personality disorder.

Histrionic

A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts.

There must be at least 5 of the following:

- Is uncomfortable in situations in which he/she is not the centre of attention
- Inappropriate sexually seductive or provocative behaviour
- Displays rapidly shifting and shallow expressions of emotions
- Consistently uses physical appearance to draw attention to self
- Has a style of speech that is excessively impressionistic and lacking in detail
- Shows self-dramatization, theatricality, exaggerated expressions of emotion
- Is suggestible, ie, easily influenced by others or circumstances
- Considers relationships to be more intimate that they actually are

Prevalence rates are 2-3% in the general population, and 10-15% in psychiatric inpatient populations. Tends to run in families. A genetic link between histrionic and antisocial personality disorder and alcoholism has been suggested.

Narcissistic
A pervasive pattern of grandiosity (in fantasy or behaviour), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts. There must be at least 5 of the following:

- Has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without achievements)
- Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
- Believes he/she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)
- Requires excessive admiration
- Has a sense of entitlement, ie, unreasonable expectations of especially favourable treatment or automatic compliance with his/her expectations
    - Is interpersonally exploitative, ie, takes advantage of others
- Lacks empathy
- Is often envious of others or believes that others are envious of him/her
- Arrogant, haughty behaviours or attitudes

Prevalence rates are 1% in the general population, and 2-16% in clinical population.

Cluster C – Individuals appear anxious or fearful

Avoidant
A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts. There must be at least 4 of the following:

- Avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection
- Is unwilling to get involved with people unless certain of being liked
- Shows restraint within intimate relationships because of the fear of being shamed or ridiculed

- Is preoccupied with being criticized or rejected in social situations
- Is inhibited in new interpersonal situations because of feelings of inadequacy
- Views self as socially inept, personally unappealing, or inferior to others
- Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing

Prevalence rates are 0.5-1% in the general population, and 10% in psychiatric outpatients.

Dependent

A pervasive and excessive need to be taken care of that leads to submissive and clinging behaviour and fears of separation, beginning by early adulthood and present in a variety of contexts. There must be at least 5 of the following:

- Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others
- Needs others to assume responsibility for most major areas of his/her life
- Has difficulty expressing disagreement with others because of fear of loss of support or approval
- Lack of initiative
- Goes to excessive lengths to obtain nurturance and support from others
- Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for him/her self
- Urgently seeks another relationship as a source of care and support when a close relationship ends
- Unrealistically preoccupied with fears of being left to take care of him/herself may be the most common personality disorder. There is no known familial pattern.

Obsessive-compulsive

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts.

There must be at least 4 of the following:

- Preoccupation with details, rules, lists, order, organization or schedules to the extent that the major point of the activity is lost
- Perfectionism that interferes with task completion
- Over conscientiousness, scrupulousness, and inflexible about matters of morality, ethics, or values.
- Unable to discard worn-out or worthless objects even if they have no sentimental value
- Reluctant to delegate tasks or to work with others unless they submit to exactly his/her way of doing things
- Adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes
- Shows rigidity and stubbornness

Prevalence rates are 1% in the general population, and 3-10% in psychiatric outpatients.

There is an increased risk of major depressive disorder and anxiety disorder, but for evidence for increased risk of OCD has not been established.

Neuroimaging in personality disorder
While the personality disorders have been arranged in 3 clusters on the basis of descriptive/clinical similarities, there is much heterogeneity, even within clusters, Neuroimaging in personality disorders is in its an early stage of development.

Psychopathic personality
Neuroimaging in psychopathic personality disorder has been reviewed. Structural studies have reported decreased prefrontal grey matter, decreased posterior hippocampal volume and increased callosal white matter, but to this point, these studies have not been confirmed. Functional studies suggest reduced perfusion and metabolism in the frontal and temporal lobes.

Two recent studies are of interest. Magnetic Resonance Imaging (MRI) has reported increased activity in the frontotemporal cortex when criminal psychopaths were dealing with emotional material (words). This was interpreted as evidence that psychopaths required to exert additional effort to deal with emotional material. The same study also reported that criminals failed to show a difference in activation of the right anterior temporal gyrus when processing abstract and concrete words. This was consistent with the researchers' proposition that psychopathy is associated with dysfunction of the right hemisphere during the processing of abstract material. They

speculated that complex social emotions such as love, empathy and guilt may call for abstract functioning, and that abstract processing deficits based in the right temporal lobe, may be a fundamental abnormality in psychopathy. These studies have not been replicated.

It has however,been argued that the neural basis of psychopathy is malfunction of the amygdala and connections to the orbitofrontal cortex.

Researchers compared the frontal lobes of three groups, 1) liars, 2) psychopaths (selected to exclude marked lying behaviour) and 3) normal controls. They found liars showed a 22-26% increase in prefrontal white matter and a 36-42% reduction in prefrontal grey/white ratios, compared to the psychopaths and normal controls. This study has not been replicated.

Borderline personality disorder

Imaging studies demonstrate biological differences between people with BPD and healthy controls. MRI studies demonstrate bilateral reduced volume of the frontal lobes, hippocampus and amygdala, and increased volume of the putamen. There are also reports of abnormalities of the cingulated cortex. Magnetic Resonance Imaging (MRI) reveals N-acetyl-aspartate (NAA) concentrations are reduced in the dorsolateral prefrontal cortex, suggesting a lower density of neurons and disturbed neuronal metabolism. These anatomical studies are consistent with functional imaging finding. Positron emission (PET) studies generally demonstrate low metabolism in regions of the frontal cortex, basal ganglia, thalamus, hippocampus and posterior cingulate. Some studies have shown hypermetabolism in the anterior cingulated gyrus, and other structures. These data are consistent with the theory that the areas of the brain which regulate and control emotions are underactive, while the limbic structures may become overactive. If substantiated, these observations may help to explain the failure of rational thought to control emotions and behaviour.

Others Schizotypal personality disorder attracts research attention because of the clinical similarities and genetic links with schizophrenia. Observations have included 1) significantly reduced left and right caudate volumes, 2) altered frontotemporal connectivity, 3) temporal lobe and basal striatal-thalamic dysfunction, and 4) reduced superior temporal gyrus volume in those with thought disorder but not in those without thought disorder. Consensus has not been reached.

Genetics

As the personality disorders are a heterogenous collection, the genetics of each will probably be different. This field is developing. Antisocial

personality disorder has perhaps received the most attention. Rhee and Waldmann in 2002, conducted a meta- analysis of 51 twin and adoption studies and found additive genetic influences (0.32), non-additive genetic influences (0.09), shared environmental influences (0.16) and non-shared environmental influences (0.43). Thus, both genetic and environmental factors are important.

Neuroticism, a long established fundamental personality trait, is mentioned above under the heading of 'Dimensional model and assessment method'. It relates to an enduring tendency to experience negative emotional states (a tendency, for example, toward anxiety, guilt and unhappiness). Neuroticism is strongly influenced by genetic factors. Impulsivity and aggressiveness are both influenced by genetics.

There appears to be a genetic basis for co-morbidity of novelty-seeking, antisocial behaviour and susceptibility to substance dependence.

Allelic variations of monoamine oxidase A (MAOA) activity appear to contribute modestly to the balance of hyperactive (impulsive-aggressive) and hypoactive (anxious-depressive) traits. There is an increased prevalence of schizotypal personality disorder in the families of people with schizophrenia. This appears to be based on genetic factors. While temporal volume reductions have been reported in both people with schizotypal personality disorder and people with schizophrenia, there may be preservation of frontal lobe volume in people with schizotypal personality disorder.

There appears to be a strong genetic component for the development of borderline personality disorder. There is a strong genetic influence on the traits which underlie this disorder, such as neuroticism, impulsivity, anxiousness, affective instability, and insecure attachment Borderline personality has been seen as a variant of psychosis, posttraumatic stress disorder and bipolar disorder, but a clear relationship has been demonstrated.

Aetiology

In common with the majority of psychiatric disorders, the aetiology of personality disorders is believed to be multi-factorial and involve genetic, intrauterine, early life experiences and precipitating and perpetuating factors. Genetic studies have been mentioned separately above.

Neuroticism already mentioned under the heading of 'Genetics', gives an example of the multifactorial aetiology of personality features/traits. In

addition to genetic factors, a contribution from childhood trauma has been demonstrated. The same applies to impulsivity and aggressiveness, which are influenced both by genetics and early life experiences.

Temperament refers to the body's biases in the modulation of conditioned behavioural responses to physical stimuli. Temperament is not entirely due to genetic factors, but can be observed in babies from birth. Temperament has a large influence on the child's interaction with others (parents). A mismatch between the temperament of the child and the parents makes for a difficult relationship, and this may predispose to the development of behavioural and personality disorders.

Prenatal factors including hormone and alcohol exposure, and intrauterine nutrition, and birth complications such as hypoxia, can be expected to impact on the personality.

Early life experiences, particularly the quality of the parent child relationships strongly influence personality development. Child abuse in all forms, particularly sexual abuse, has deleterious effects, and may be associated with the development of borderline personality disorder.
By definition personality disorders are lifelong, thus the concept of precipitating factors may be synonymous with early life experience. However, personality disorder may only become apparent with the loss of an important support, such as caring parent, or when the individual is exposed to additional stress, such the responsibility for the care of a new baby.

Perpetuating factors include the individual's habitual manner of responding. That is, illegal drug use, aggressive outbursts, and inappropriate sexual provocation, for example, are likely to damage relationships and lead to loss and distress. The individual with a personality disorder has limited ability to deal with stress in an adaptive manner, thus, a self-reinforcing maladaptive cycle emerges.

3.5 Management

Management begins with a full assessment and the exclusion of other psychiatric disorders such as major depression. Co-morbid conditions should be managed in the standard manner.

Treatment depends on the nature of the nature of the personality disorder, patient willingness to engage in treatment and the available resources (availability of specialist psychotherapists and treatment programs).

Personality disorder is often regarded as resistant to psychiatric treatment and limited treatment is offered. This is an unduly pessimistic attitude, as relief and personal growth can occur. However, prolonged treatment may be necessary and complete recovery is the exception rather than the rule. Individuals with antisocial personality disorder may be unable to enter into a therapeutic relationship and are generally regarded as untreatable in all but specialized (usually forensic) units.

Psychotherapy is the primary treatment. This may take many forms. Dynamic psychotherapy (with roots in Freudian analysis) and cognitive behaviour therapy (which is focused more on thinking processes and behaviour) both have much to offer. Supportive psychotherapy, in which the therapist mainly supports, educates and encourages the patient through the trials of life "buys time" and fosters the growing process. Psychotherapy may be conducted as individual or group sessions. In specialized practice the patient may attend both.

Medication may have a place in the management of specific symptoms. Antidepressants (such as fluoxetine) have a place in relieving anxiety and distress, even in the absence of full major depressive disorder. The benzodiazepines are best avoided because to the potential for addiction. Irritability may be helped by a trial of a mood stabilizer (such as sodium valproate) or an antipsychotic (such as low dose chlorpromazine).

It is important to involve the family (with the permission of the patient). A clear explanation at an early stage, of the diagnosis, the difficulties experienced by the patient and the clinician, and the likely prognosis, will be of assistance to all involved.

The management of people with borderline personality presents special challenges. These people are usually angry much of the time and can move from happy to unhappy in response to minor events. They are particularly inclined to self-mutilation (cutting) and suicidal behaviour. Many people with borderline personality disorder have a limited ability to understand and describe the way they are feeling; they are limited to feeling good/happy or bad/distressed/tense/angry. They have limited ability to deal with their bad/distressed/tense/angry state. When they are in this unwelcome state they frequently get relief from cutting themselves. They report feeling a sense of great relief when blood flows out. Such cutting can be distinguished from attention seeking behaviour (although some subsequent attention may also be rewarding) and the intention to die. However, suicide may be attempted and may be successful.

People with borderline personality (as with people with other personality disorders) are best managed in the community with the help of an experienced psychotherapist/counsellor. It is better for them to live in the "real world" and learn to deal with the challenges which the "real world" presents. However, admission to hospital for a brief time (2-3 days) may be indicated when they are in the grip of the bad/distressed/tense/angry state. Such admissions are for safety purposes only. Being in hospital for long periods increases dependency and a sense of impotence and failure. Hospital is an artificial environment with little opportunity for the growth of a sense of autonomy and competence. The best outcome may be achieved where the patient, an out-patient psychotherapist and a psychiatric inpatient unit cooperate in formulating a plan of regular out-patient psychotherapy and easy admission and rapid discharge (no inpatient psychotherapy) at times of crisis.

3.6 Prognosis

The prognosis depends on the nature and severity of the personality disorder. Cluster B disorders, characterized by erratic and impulsive behaviour usually improve with age (after 35 years). These people (as with the rest of us) mature over time and become less volatile, violent and irritable. Cluster C disorders, characterized by anxious and fearful disposition tend to become more confident and assertive. Cluster A disorders, characterized by eccentricity may not change markedly.

Management as detailed above may prove helpful. Suicide may occur. Some estimates are that people with severe borderline personality with co-morbid substance abuse has a 50% lifetime risk of suicide. However, as stated, maturation brings improvement and if these people stay alive, the risk of suicide eventually declines.

4.0 CONCLUSION

5.0 SUMMARY

This unit has looked into personality disorders, personality trait disturbances, personality pattern disturbances, and the management of personality disturbances as well as distinctions between the disorders and the diagnostic criteria by DSM.

6.0 TUTOR-MARKED ASSIGNMENT

Visit the nearest psychiatric unit closest to you, observe 5 patients with the diagnosis of schizophrenia and note the personality traits present in them. Share your experience with your colleagues in your discussion forum.

SELF-ASSESSMENT EXERCISE

i. Classify the personality disorders according to DSM
ii. Briefly discuss the antisocial personality disturbances.

7.0 REFERENCES/FURTHER READING

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UNIT 3 ANTISOCIAL PERSONALITY DISORDER

CONTENTS

1.0 INTRODUCTION

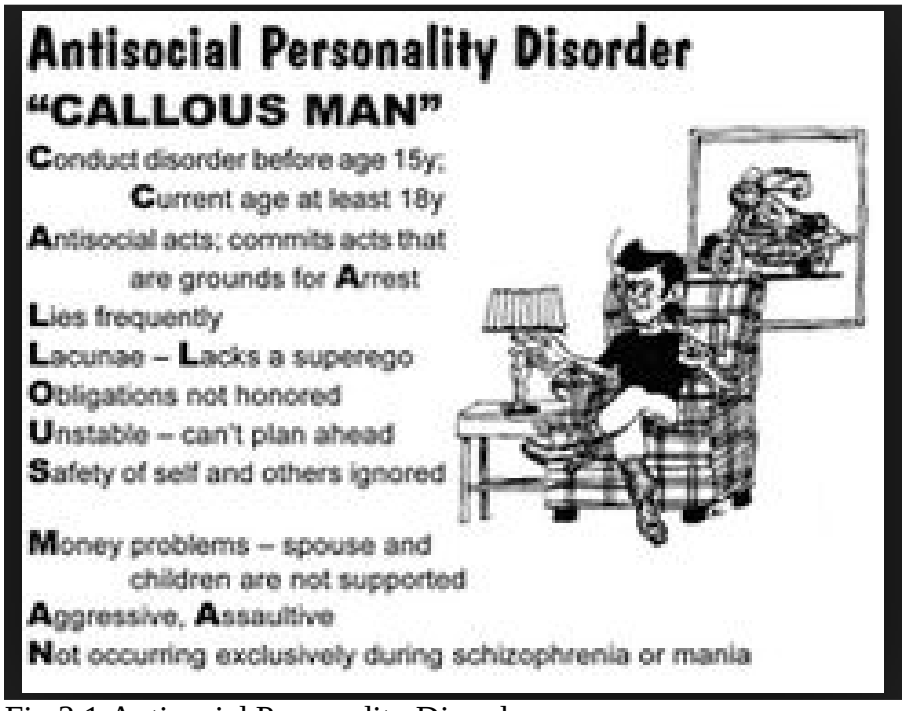

Fig 3.1 Antisocial Personality Disorder
www.pinterest.com

The last unit introduced you to the concept of personality, pattern and traits of personality disorders as well as the management of personality disorders. This unit will expand your knowledge on antisocial personality disorders.

Antisocial personality disorder (ASPD; also referred to as psychopathy, sociopathy, and dissocial personality disorder) is a mental disorder characterized by a pervasive pattern of disregard for, and violation of the rights of others. Signs and symptoms of ASPD begin in childhood or early adolescence, and ASPD is diagnosed only in individuals who have a history of symptoms before age 15. Formal diagnosis of ASPD is delayed until age 18 or older, because personality development is considered incomplete before age 18, and ASPD traits may not persist into adulthood. Deceit and manipulation are central features of ASPD, and it is recommended that information gathered during assessment of an individual suspected of having ASPD be confirmed by outside sources; such as family members or an intimate partner.

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), an individual may be diagnosed with ASPD if he or she meets three of the following criteria: failure to conform to laws and regulations by repeating acts punishable by law; deceitfulness, repeated lying, conning, or use of aliases; failure to plan ahead, resulting in impulsivity; aggression, as demonstrated by repeated fights or assaults; reckless disregard for safety of self or others; persistent irresponsibility, as demonstrated by failure to keep a job or pay bills; and lack of remorse, as indicated by rationalization or indifference about having hurt, mistreated, or stolen from another. An individual with ASPD will often minimize the harm he or she has caused another, or may blame the victim for the crime.
The differential diagnoses include borderline personality disorder, histrionic personality disorder, paranoid personality disorder, narcissistic personality disorder, and personality change due to a general medical condition. Assessment for substance abuse is usually part of the diagnostic process. If signs and symptoms occur exclusively during episodes of schizophrenia or mania, a diagnosis of ASPD cannot be made.

Treatment includes psychotherapy to resolve individual, interpersonal, and/or occupational difficulties. Medications may be prescribed for comorbid mood disorders (e.g., depression or anxiety) or for transient psychotic episodes. ASPD is difficult to treat because its characteristics are deeply entrenched in a person’s personality, and because individuals with ASPD often do not take responsibility for their behavior and may refuse treatment. ASPD is commonly diagnosed and treated in individuals who are in prison or substance abuse treatment facilities.

2.0 OBJECTIVES

At the end of this unit you will be able to:

- Describe an individual with antisocial personality disorder
- Explain the aetiological theories of antisocial personality disorders
- Carry out an assessment of a client with antisocial personality disorder
- State he risk factors of antisocial personality disorder

3.0 MAIN CONTENT

3.1 Anti Social Personality Disorder

Prior to the DSM individuals diagnosed as having antisocial personalities were referred to as psychopaths, sociopaths, or impulsive characters.

These terms are often used interchangeably. The six behavioural traits of antisocial personality are:

- Being antisocial or performing crime against the society
- Being driven by uncontrollable desires to seek excitement
- Acting highly impulsively with no stable goals
- Acting aggressively and reacting to frustration with fury
- Feeling little guilt or remorse when committing amoral act
- Having a warped capacity for love, i.e., being cold and compassionless

It is the total personality that constitute the syndrome rather than a single behavior, antisocial behavior alone e.g. drinking, stealing, fighting and sexual assault do not constitute antisocial personality disorder.

Pathology in antisocial personalities is manifested interpersonally; therefore, the diagnosis of antisocial personality disorders is made based on the client's history and on psychological testing.

3.2 Definition and Epidemiology

A condition in which individual exhibit a pervasive disregard for the law and the rights of others.

Sociopaths and psychopaths describe antisocial personality disorder. It affects men three times more and prevalent in prison population. Early adolescence is a critical time for antisocial personality disorder and it is a chronic disorder.
Intensity of symptoms tend to peak during the teenage years and early 20s and then may decrease overtime.

3.3 Aetiological Theories of Antisocial Personality Disorder

The DSM-IV has identified criteria for the anti social personality disorder. Research has also supported four hypotheses regarding the etiology of antisocial disorders as:

- Psychodynamic issues
- Family influences
- Social and environmental influences
- Biological influences

Note that antisocial behaviours are not a single entity. Recurrently antisocial persons, especially those who are frequently violent, may have multiple influences and vulnerabilities that predispose them to develop antisocial personality disorders. The following theories identify numerous influences that may cause in varying degrees and combinations, an individual to develop an antisocial personality.

Psychodynamic issues
From psychodynamic point of view, psychopathology of antisocial personality disorder is thought to be caused by a fixed disturbance of developmental growth.

A child who has drifted through a series of foster homes, who has been abandoned by his parents, or who has suffered emotional deprivation may show antisocial traits early in life.

Lack of validation, emotional warmth, and physical security interfere with normal ego development. Ego pathology in early life is further compounded during the stage of super ego development and result in disturbances in superego formation. These disturbances are manifested by the individual's failure to develop control over the expression of his or her basic needs. Consequently, personality defenses are designed to gratify the impulses and to provide pleasure and immediate relief of tension. The pleasures have primitive, oral quality and are related to the physiological

responses, such as those experienced after drinking, drug, sex, or acquiring property. People with these disorders have a limited capacity to experience pleasure in interpersonal relationships or for warm and sincere relationships. Missing is the ability to love, form friendships, and experience loyalty.

People with personality disorders, like all of us, use various defense mechanisms. When the defense mechanisms of people with personality disorders are effective, anxiety and depression are kept out of awareness. The unwillingness to avow feelings of anxiety and depression is a major reason people with personality disorders avoid treatment. Once defenses are lowered, painful feelings of anxiety and depression often surface, and people with antisocial personalities may employ the other defenses, such as aggression or sexual acting out. Use of alcohol or illicit drugs is also common among people with antisocial personality disorders.

Family influences

The family histories of antisocial persons seem to play an important etiology role. Frequently, the antisocial individual was an unwanted child or illegitimate.

Often, parents of antisocial individuals are divorced or deserted their families. As children, many antisocial individuals were exposed to violent tempers, physical abuse, cruelty and sexual abuse by their caretakers.

Violent behavior has its origin in early extraordinary physical and sexual abuse. Furthermore, in dysfunctional families, inconsistent and ineffective discipline can teach the child to be deceitful, superficial, and narcissistic. The teaching of moral values and behaviours may also be lacking in these families.

Social and environmental influences

Society and environment influence the family's child-rearing practices. Longitudinal survey found several indicators of future antisocial behaviour which includes; economic deprivation, family criminality, poor child-rearing practices, school failure, hyperactivity, impulsivity and attention deficit.

It is almost a common consensus that, most violent crime is committed by men in their ages 18 to 24. The more males in this age group in a given population, the higher the crime rate (Farrington, 1989).

Antisocial personality disorder can be detected in early adolescence (APA, 1994), predominant characteristics include emotional immaturity and impulsive need for gratification. These preadolescents or adolescents may steal, run away, act destructively, be quarrelsome, demonstrate guiltlessness, and act openly rebellious. This bahaviour is generally directed toward parents and teachers.

Biologycal influences

Genetic and biological studies concerning the antisocial individual yield interesting data. Conclusions based on studies of antisocial individuals have been summarized by Kaplan and Sadock as:

1. There appears to be a genetic predispostition to antisocial behaviour that is also associated with alcoholism
2. Adopted children of criminal fathers are more likely to become delinquent than adopted children of noncriminal fathers
3. There is a greater correlation for criminal behaviour in monozygotic than in dizogotic twins
4. Learning disabilities and mild mental retardation are more prevalent in the criminal population than in general population
5. Electroencephalographic changes are common in antisocial and borderline patients
6. Depletion of serotonin as well as its metabolite 5-hydroxyindoleacetic acid (5-HIAA), is seen in people who are impulsive and aggressive
7. Hormonal secretions, such as increased levels of testosterone. 17-estradiol, and estrone, may be linked with impulsive behaviour.
   Researchers have also found that psychophysiological measures, such as poor skn conductance conditioning and lower resting heart rate levels are significant predictors of antisocial behaviours (Reine and Mednick, 1989). So,

3.4 Risk Factors and Causes of Antisocial Behaviour

History of child abuse, deprived environment, neglect, antisocial environment in home, having an antisocial parent, alcoholic parent, attention deficit disorder and reading disorders.

Causes

- Idiopathic
- Hereditary/genetics

- Environmental influence-chaotic home, punitive school, improper community and work environment, family conflicts, lack of control, abusive alcoholic parents, drug addicts.
- Difficulty in developing emotional bonds
- Few healthy role models for behavior
- No rewards for socially acceptable actions
- Conduct problem
- Abusive or neglectful childhood environment.

3.5 Manifestations

- Indifferent to the needs of others
- Manipulate through deceit or intimidation, may have trouble holding down job a job
- Fails to pay debts or fails to fulfill parenting or work responsibilities
- Usually lonely
- Aggressive, violent, involves in fight
- Frequent encounters with law
- Persistent lying or stealing
- Tendency to violate the rights of others (property, physical, sexual, emotional, legal)
- A persistent agitated or depressed feeling
- Inability to tolerate boredom
- Disregard for hurting others
- Impulsiveness
- Inability to make or keep friends
- Reckless behaviour

SELF-ASSESSMENT EXERCISE

Patient History
Ask about personal/family mental health history to evaluate for predisposing factors and comorbidities; while taking patient history, assess level of threat to others

Physical Findings of Particular Interest
Physical examination may identify an underlying medical cause of signs and symptoms

Laboratory Tests That May Be Ordered
There are no laboratory tests specific to the diagnosis of ASPD
Toxicology screen may be ordered to assess for comorbid substance abuse

Testing for HIV and other sexually transmitted diseases (STDs) may be warranted, because patients with ASPD often exhibit poor impulse control and act without regard to risk

Other Diagnostic Tests/Studies
Complete psychological assessment is necessary to determine the validity of an ASPD diagnosis; assess for comorbid mood or personality disorders
Minnesota Multiphasic Personality Inventory-2 (MMPI-2) is usual to assess for a range of personality and mood disorders

3.6 Management

Treatment Goals
Promote Optimum Psychiatric and Social Functioning
Assess all physiologic systems for underlying physical or substance-related abnormalities and review laboratory/diagnostic test results; immediately report abnormalities and treat, as ordered.

Assess level of threat to others; follow facility protocols for mandatory reporting of criminal activity, and request facility security to provide patient surveillance, if appropriate. If possible, provide nurse continuity for patient care
Request referral to a mental health clinician for assessment and treatment
Individual/group/family therapy is recommended, particularly if the patient is young because he or she may be receptive to change—

Administer prescribed antidepressants (e.g., selective serotonin reuptake inhibitors [SSRIs], e.g., fluoxetine, venlafaxine) to decrease aggressiveness and irritability
Administer antipsychotic agents (e.g., clozapine, olanzapine), as ordered, for distortions in thinking

Monitor treatment efficacy and for adverse effects, and educate the patient/family about potential adverse effects

Promote Emotional Well-Being and Educate
Assess your patient for anxiety, depression, and adequate coping skills; educate and encourage discussion of ASPD diagnosis, potential complications, treatment risks and benefits, and the importance of long-term treatment regimen adherence
Request referral, if appropriate, to a social worker for identification of local resources for support groups or programs for substance use/abuse rehabilitation

Food for Thought
Signs and symptoms of ASPD may remit when the individual reaches his or her 40s, especially with respect to criminal behavior and substance abuse

Accumulating evidence suggests that ASPD is caused by neurochemical abnormalities, leading some experts to advocate the use of pharmacotherapy in the treatment of ASPD. Although, authors of a systematic review published in 2010 found insufficient evidence to evaluate the effectiveness of pharmacological interventions for ASPD (Khalifa et al., 2010)

Red Flags
ASPD often involves a high rate of violence; individuals with ASPD are more likely than others to die prematurely or be permanently disabled by violent means (e.g., by suicide, accident, or homicide)

Due to increased risk for overdose, tricyclic antidepressants and monoamine oxidase inhibitors (MAOIs) are avoided in patients with personality disorders

What do you need to tell the patient/patient's family?
Emphasize the importance of continued psychiatric surveillance, strict adherence to the medication regimen, and seeking immediate medical attention for adverse drug effects or new/worsening signs and symptoms of ASPD

Nursing Management
- Observe the behaviour, set limits which are acceptable
- Provide safe and calm environment for patient to express his feelings
- Explain in low tone to the patient, his unacceptable behaviour which is harmful both to him and others
- Teach relaxation exercises and motivate patient to practice it
- Encourage patient to participate in divisional activities, where he can express his feelings in an acceptable manner like drawing, music writing
- Teach self control behaviour modification techniques and allow to practice
- Administer the prescribed medication
- Assign some responsibilities to the patient and observe how he is able to do it

- Maintain non-stimulating environment to lessen aggressive feelings, keep away all dangerous objects within reach to prevent self injury or to others
- Teach coping strategies, provide opportunities to practice
- If aggressive behaviour is noticed, mechanical restraints may be necessary
- Provide positive feedback for healthy independent behaviour
- Enhance problem solving skill, patient's strengths and coping skills
- Involve the patient in non-competitive activities and tasks first, and then allow him to progress into competitive activities

4.0 CONCLUSION

5.0 SUMMARY

Antisocial personality disorder has been explained as a condition in which individuals exhibit a pervasive disregard for the law and the right of others.

Sociopaths and psychopath describes antisocial personality disorder. It affects men three times more than men and prevalent in prison population. Early adolescence is a critical time for antisocial disorder and it is a chronic disorder. Intensity of symptoms tends to peak during the teenage years and early 20s and then may decrease over time.

This unit has further increase your knowledge antisocial personality disorder as one major common among criminals and people with crime tendencies.

6.0 TUTOR-MARKED ASSIGMENT

Visit a correctional home closest to you and assess at least five inmates for features of antisocial personality.

Share your experience in the discussion forum with your classmates.

SELF-ASSESSMENT EXERCISE

i. Discuss four characteristic common to all personality disorders
ii. Differentiate between the psychodynamic aetiological theory and the family aetiological theory of antisocial personality disorders

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UNIT 4 BORDERLINE PERSONALITY DISORDER

CONTENT

1.0 INTRODUCTION

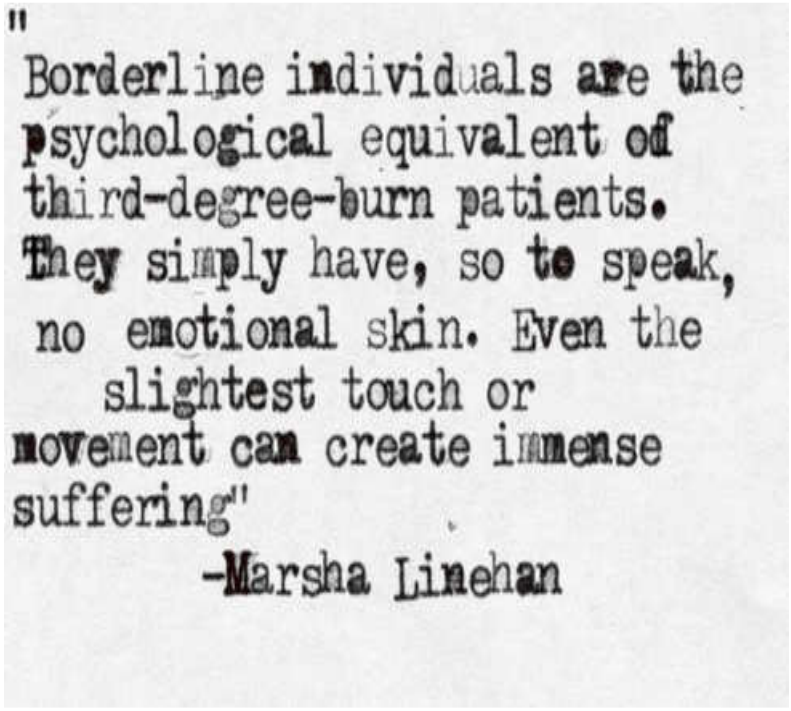

Fig. 4.1 Borderline Personality Disorder
furry-lover.blogspot.com

Individuals with Borderline Personality Disorder have intense, unstable close relationships, which alternate between extremes of idealization and devaluation. They often make frantic efforts to avoid real or imagined abandonment. They have marked negative emotions. They have frequent and intense experiences of high levels of a wide range of negative emotions (e.g., anxiety, depression, guilt/shame, worry). Antagonism: like many young teenagers, adults with this disorder have highly changeable moods and intense anger. Characteristically, these intense emotional episodes last only a few hours and only rarely more than a few days. Self harm and repeated, impulsive suicide attempts are seen in the more severely ill.

You will learn more about this important most common personality disorder in this unit, after which you will be able to manage the individual patient with this disorder better.

2.0 OBJECTIVES

After studying this unit, you will be able to:

- Describe borderline personality disorder
- State the manifestations of borderline personality disorder
- Enumerate other illnesses co-occurring with borderline personality disorder
- Identify the risk factors for borderline personality disorder
- Describe how borderline personality disorder is diagnosed
- Discuss the treatment of borderline personality disorder
- State what to do to help a friend or relative who has borderline personality disorder

3.0 MAIN CONTENT

3.1 What Is Borderline Personality Disorder?

Borderline personality disorder is a serious mental illness marked by unstable moods, behavior, and relationships. In 1980, the Diagnostic and Statistical Manual for Mental Disorders, Third Edition (DSM-III) listed borderline personality disorder as a diagnosable illness for the first time. Most psychiatrists and other mental health professionals use the DSM to diagnose mental illnesses.

Because some people with severe borderline personality disorder have brief psychotic episodes, experts originally thought of this illness as atypical, or borderline, versions of other mental disorders.While mental health experts now generally agree that the name "borderline personality disorder" is misleading, a more accurate term does not exist yet.
Most people who have borderline personality disorder suffer from:

- Problems with regulating emotions and thoughts
- Impulsive and reckless behavior
- Unstable relationships with other people.

People with this disorder also have high rates of co-occurring disorders, such as depression, anxiety disorders, substance abuse, and eating disorders, along with self-harm, suicidal behaviors, and completed suicides.

According to data from a subsample of participants in a national survey on mental disorders, about 1.6 percent of adults in the United States have borderline personality disorder in a given year.

Borderline personality disorder is often viewed as difficult to treat. However, recent research shows that borderline personality disorder can be treated effectively, and that many people with this illness improve over time.

3.2 Symptoms of Borderline Personality Disorder

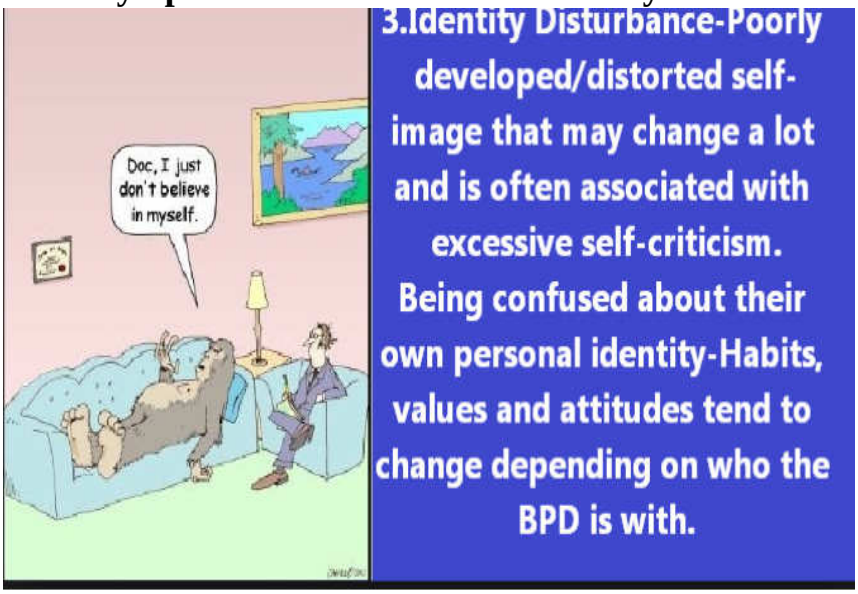

Fig.4.2 Symptoms of Borderline Personality Disorder
reducingourmentalillnesses1atatime.blogspot.com

Borderline personality disorder usually begins during adolescence or early adulthood. Some studies suggest that early symptoms of the illness may occur during childhood.
Some people with borderline personality disorder experience severe symptoms and require intensive, often inpatient, care. Others may use some outpatient treatments but never need hospitalization or emergency care. Some people who develop this disorder may improve without any treatment.

According to the DSM, Fourth Edition, Text Revision (DSM-IV-TR), to be diagnosed with borderline personality disorder, a person must show an enduring pattern of behavior that includes at least five of the following symptoms:

- Extreme reactions—including panic, depression, rage, or frantic actions—to abandonment, whether real or perceived
- A pattern of intense and stormy relationships with family, friends, and loved ones, often veering from extreme closeness and love (idealization) to extreme dislike or anger (devaluation)
- Distorted and unstable self-image or sense of self, which can result in sudden changes in feelings, opinions, values, or plans and goals for the future (such as school or career choices)
- Impulsive and often dangerous behaviors, such as spending sprees, unsafe sex, substance abuse, reckless driving, and binge eating
- Recurring suicidal behaviors or threats or self-harming behavior, such as cutting
- Intense and highly changeable moods, with each episode lasting from a few hours to a few days
- Chronic feelings of emptiness and/or boredom
- Inappropriate, intense anger or problems controlling anger
- Having stress-related paranoid thoughts or severe dissociative symptoms
- such as feeling cut off from oneself, observing oneself from outside the body, or
  losing touch with reality.

Seemingly mundane events may trigger symptoms. For example, people with borderline personality disorder may feel angry and distressed over minor separations—such as vacations, business trips, or sudden changes of plans—from people to whom they feel close. Studies show that people with this disorder may see anger in an emotionally neutral faceand have a

stronger reaction to words with negative meanings than people who do not have the disorder.

3.3 Illnesses Often Co-exist with Borderline Personality Disorder

Borderline personality disorder often occurs with other illnesses. These co-occurring disorders can make it harder to diagnose and treat borderline personality disorder, especially if symptoms of other illnesses overlap with the symptoms of borderline personality disorder.
Women with borderline personality disorder are more likely to have co-occurring disorders such as major depression, anxiety disorders, or eating disorders. In men, borderline personality disorder is more likely to co-occur with disorders such as substance abuse or antisocial personality disorder.

According to the NIMH-funded National Comorbidity Survey Replication—the largest national study to date of mental disorders in U.S. adults about 85 percent of people with borderline personality disorder also meet the diagnostic criteria for another mental illness.
Other illnesses that often occur with BPD include diabetes, high blood pressure, chronic back pain, arthritis, and fibromyalgia. These conditions are associated with obesity, which is a common side effect of the medications prescribed to treat borderline personality disorder and other mental disorders. For more information, see the section, “How is borderline personality disorder treated?”

3.4 Risk Factors for Borderline Personality Disorder

Research on the possible causes and risk factors for borderline personality disorder is still at a very early stage. However, scientists generally agree that genetic and environmental factors are likely to be involved.

Studies on twins with borderline personality disorder suggest that the illness is strongly inherited. Another study shows that a person can inherit his or her temperament and specific personality traits, particularly impulsiveness and aggression. Scientists are studying genes that help regulate emotions and impulse control for possible links to the disorder.

Social or cultural factors may increase the risk for borderline personality disorder. For example, being part of a community or culture in which unstable family relationships are common may increase a person’s risk for the disorder. Impulsiveness, poor judgment in lifestyle choices, and other consequences of BPD may lead individuals to risky situations. Adults with

borderline personality disorder are considerably more likely to be the victim of violence, including rape and other crimes.

3.5 Diagnosis of Borderline Personality Disorder

Unfortunately, borderline personality disorder is often under diagnosed or misdiagnosed.
A mental health professional experienced in diagnosing and treating mental disorders such as a psychiatrist, psychologist, clinical social worker, or psychiatric nurse—can detect borderline personality disorder based on a thorough interview and a discussion about symptoms. A careful and thorough medical exam can help rule out other possible causes of symptoms.

The mental health professional may ask about symptoms and personal and family medical histories, including any history of mental illnesses. This information can help the mental health professional decide on the best treatment. In some cases, co-occurring mental illnesses may have symptoms that overlap with borderline personality disorder, making it difficult to distinguish borderline personality disorder from other mental illnesses. For example, a person may describe feelings of depression but may not bring other symptoms to the mental health professional's attention.

No single test can diagnose borderline personality disorder. Scientists funded by NIMH are looking for ways to improve diagnosis of this disorder. One study found that adults with borderline personality disorder showed excessive emotional reactions when looking at words with unpleasant meanings, compared with healthy people. People with more severe borderline personality disorder showed a more intense emotional response than people who had less severe borderline personality disorder.

3.6 How is Borderline Personality Disorder Treated?

Borderline personality disorder can be treated with psychotherapy, or "talk" therapy. In some cases, a mental health professional may also recommend medications to treat specific symptoms. When a person is under more than one professional's care, it is essential for the professionals to coordinate with one another on the treatment plan.

The treatments described below are just some of the options that may be available to a person with borderline personality disorder. However, the research on treatments is still in very early stages. More studies are needed

to determine the effectiveness of these treatments, who may benefit the most, and how best to deliver treatments.

Psychotherapy

Psychotherapy is usually the first treatment for people with borderline personality disorder. Current research suggests psychotherapy can relieve some symptoms, but further studies are needed to better understand how well psychotherapy works.

It is important that people in therapy get along with and trust their therapist. The very nature of borderline personality disorder can make it difficult for people with this disorder to maintain this type of bond with their therapist.

Types of psychotherapy used to treat borderline personality disorder include the following:

1. Cognitive behavioral therapy (CBT). CBT can help people with borderline personality disorder identify and change core beliefs and/or behaviors that under-lie inaccurate perceptions of themselves and others and problems interacting with others. CBT may help reduce a range of mood and anxiety symptoms and reduce the number of suicidal or self-harming behaviors.
2. Dialectical behavior therapy (DBT). This type of therapy focuses on the concept of mindfulness, or being aware of and attentive to the current situation. DBT teaches skills to control intense emotions, reduces self-destructive behaviours, and improves relationships. This therapy differs from CBT in that it seeks a balance between changing and accepting beliefs and behaviors.
3. Schema-focused therapy. This type of therapy combines elements of CBT with other forms of psychotherapy that focus on reframing schemas, or the ways people view themselves. This approach is based on the idea that borderline personality disorder stems from a dysfunctional self-image—possibly brought on by negative childhood experiences—that affects how people react to their environment, interact with others, and cope with problems or stress.

Families of people with borderline personality disorder may also benefit from therapy. The challenges of dealing with an ill relative on a daily basis can be very stressful, and family members may unknowingly act in ways that worsen their relative's symptoms.

Some therapies, such as DBT-family skills training (DBTFST), include family members in treatment sessions. These types of programs help families develop skills to better understand and support a relative with

borderline personality disorder. Other therapies, such as Family Connections, focus on the needs of family members. More research is needed to determine the effectiveness of family therapy in borderline personality disorder. Studies with other mental disorders suggest that including family members can help in a person's treatment.

Other types of therapy not listed in this booklet may be helpful for some people with borderline personality disorder. Therapists often adapt psychotherapy to better meet a person's needs. Therapists may switch from one type of therapy to another, mix techniques from different therapies, or use a combination therapy.

Some symptoms of borderline personality disorder may come and go, but the core symptoms of highly changeable moods, intense anger, and impulsiveness tend to be more persistent. People whose symptoms improve may continue to face issues related to co-occurring disorders, such as depression or post-traumatic stress disorder. However, encouraging research suggests that relapse, or the recurrence of full-blown symptoms after remission, is rare. In one study, 6 percent of people with borderline personality disorder had a relapse after remission.

Therapy can be provided one-on-one between the therapist and the patient or in a group setting. Therapist-led group sessions may help teach people with borderline personality disorder how to interact with others and how to express themselves effectively.

One type of group therapy, Systems Training for Emotional Predictability and Problem Solving (STEPPS), is designed as a relatively brief treatment consisting of 20 two-hour sessions led by an experienced social worker. Scientists funded by NIMH reported that STEPPS, when used with other types of treatment (medications or individual psychotherapy), can help reduce symptoms and problem behaviors of borderline personality disorder, relieve symptoms of depression, and improve quality of life.The effectiveness of this type of therapy has not been extensively studied.

Medications

No medications have been approved by the U.S. Food and Drug Administration to treat borderline personality disorder. Only a few studies show that medications are necessary or effective for people with this illness. However, many people with borderline personality disorder are treated with medications in addition to psychotherapy. While medications do not cure BPD, some medications may be helpful in managing specific symptoms. For some people, medications can help reduce symptoms such

as anxiety, depression, or aggression. Often, people are treated with several medications at the same time, but there is little evidence that this practice is necessary or effective.

Medications can cause different side effects in different people. People who have borderline personality disorder should talk with their prescribing doctor about what to expect from a particular medication.

Other Treatments

Omega-3 fatty acids. One study done on 30 women with borderline personality disorder showed that omega-3 fatty acids may help reduce symptoms of aggression and depression. The treatment seemed to be as well tolerated as commonly prescribed mood stabilizers and had few side effects. Fewer women who took omega-3 fatty acids dropped out of the study, compared to women who took a placebo (sugar pill).

With proper treatment, many people experience fewer or less severe symptoms. However, many factors affect the amount of time it takes for symptoms to improve, so it is important for people with borderline personality disorder to be patient and to receive appropriate support during treatment.

3.7 How can you Help a Friend or Relative who has Borderline Personality Disorder?

If you know someone who has borderline personality disorder, it affects you too. The first and most important thing you can do is help your friend or relative get the right diagnosis and treatment. You may need to make an appointment and go with your friend or relative to see the doctor. Encourage him or her to stay in treatment or to seek different treatment if symptoms do not appear to improve with the current treatment.

To help a friend or relative you can:

- Offer emotional support, understanding, patience, and encouragement—change can be difficult and frightening to people with borderline personality disorder, but it is possible for them to get better over time
- Learn about mental disorders, including borderline personality disorder, so you can understand what your friend or relative is experiencing
- With permission from your friend or relative, talk with his or her therapist to learn about therapies that may involve family members.

- Never ignore comments about someone's intent or plan to harm himself or herself or someone else. Report such comments to the person's therapist or doctor. In urgent or potentially life-threatening situations, you may need to call the police.

4.0 CONCLUSION

Individuals with Borderline Personality Disorder have intense, unstable close relationships, which alternate between extremes of idealization and devaluation. They often make frantic efforts to avoid real or imagined abandonment. They have marked negative emotions. They have frequent and intense experiences of high levels of a wide range of negative emotions

5.0 SUMMARY

Borderline personality disorder (BPD) is a mental health disorder that generates significant emotional instability. This can lead to a variety of other stressful mental and behavioral problems.

With borderline personality disorder, individual may have a severely distorted self-image and feel worthless and fundamentally flawed. Anger, impulsiveness and frequent mood swings may push others away, even though sufferer may desire to have loving and lasting relationships.

You have learned about the features of borderline personality disorder in this unit, you are in no doubt equipped better now to help individual with borderline personality disorder.

6.0 TUTOR-MARKED ASSIGNMENT

Assess yourself and see how many of the characteristics discussed above can be found in you, identify what you can do to help yourself if you discover you have borderline personality problem.

SELF-ASSESSMENT EXERCISE

i. Describe borderline personality disorder
ii. State the manifestations of borderline personality disorder
iii. Enumerate other illnesses co-occurring with borderline personality disorder
iv. Identify the risk factors for borderline personality disorder
v. Describe how borderline personality disorder is diagnosed
vi. Discuss the treatment of borderline personality disorder

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