BASIC PSYCHIATRIC NURSING

Irving

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This book is dedicated
To N.G.
and
All of My Students

PREFACE TO THE SECOND EDITION

In this second edition, I have tried to make the book more useful to instructors and students of psychiatric nursing by implementing some of their suggested changes. I have added two new chapters: Chapter 9, "Reactions to the Stress of Adolescence," and Chapter 16, "Community Mental Health and Psychiatric Nursing." Other new material that has been added includes sections on transactional analysis, crisis intervention, and behavior modification. The references at the end of each chapter and the Classification of Common Psychoactive Drugs have been updated. The order of the contents of the book has been changed so that the chapter on the nurse-patient relationship follows the chapter on psychiatric treatment, which seems to be a more logical sequence.

In general the basic concepts regarding behavior in health and illness have changed very little in the past five years. The purpose of the book remains the same, to help the nurse learn ways of relating effectively to all people, but particularly to the sick. I hope this edition will be as helpful to instructors and students of psychiatric nursing as the first edition seemed to be.

I am indebted to a number of people for their help and support in rewriting this second edition. Let me specifically mention three of them: my colleagues, Joanne Griffith, R.N., and Sandy Staples, R.N., for reading and commenting on the material; and Belva Carter, Library Assistant, for her invaluable assistance with the reference material.

SUSAN IRVING

PREFACE TO THE FIRST EDITION

Because of the many changes in attitudes and approaches to mental health and illness in recent years, psychiatric nursing is in a period of transition. It is no longer acceptable for the nurse to give merely custodial care to the hospitalized patient. Nursing care is expected to be therapeutic, personalized, comprehensive, preventive, and rehabilitative. Such care requires increased knowledge and understanding of human behavior, and greater ability and skill in human relations on the part of all nurses.

This book is written in an effort to help the nurse learn ways of relating to all people effectively enough to relieve suffering, increase security, and promote health in her care of patients. Although the focus of the book is primarily upon psychiatric nursing and the care of hospitalized patients, the same principles apply in any field of human endeavor, and in all relationships between people. The material in the book is aimed toward acquainting the nurse with the dimensions of health and illness, the corresponding dimensions of care and treatment, and her place on the treatment team.

I do not mean to be presumptuous in offering answers to all kinds of nursing problems, but I do believe that effective patient care is based upon a successful relationship between the patient and some helping person. That helping person may or may not be the nurse. If it is to be the nurse, she must prepare herself for the task of helping others by increasing her knowledge, understanding, and skill in human relations. We all need to work toward closing the gap between our great scientific progress and the lack of personal involvement among people. Then, and only then, will our work, our lives, our world be made more safe and secure. In his prayer of thanksgiving for the safe return of the astronauts from the

first moon landing, the chaplain of the recovery ship said it this way: "May we be inspired to move toward new horizons in the spirit of brotherhood, human concern, and mutual respect for all mankind."

Although I assume the responsibility for what is written here, the material does not belong only to me. Some of the thoughts and words are those of other people, but they have become so much a part of me and my teaching that I am no longer able to identify their origins. This book is a result of many rewarding personal interactions, both successful and unsuccessful, and the culmination of a life's ambition to be of service to other people. It is not possible for me to thank each person from whom I have gained something that has become a part of this book. However, I would like to thank certain individuals who have had a specific and identifiable part in its creation: Richard Fredericks, M.D.; Raymond L. Leidig, M.D.; Joy R. Joffe, M.D.; Mr. Robert Greene, Pharmacist; Mrs. Lois Brevik, Librarian; and secretaries Mrs. Lynn Starkovich and Mrs. Barbara Vincent.

I would like to express my special thanks to my friends and colleagues, Mrs. Phyllis Cornwall, R.N., and Mrs. Joanne Griffith, R.N., upon whom I relied for assistance and suggestions. Finally, I would like to give most of the credit for this book to the patients, instructors, and students with whom I have worked during the past twenty-five years, because without them it would never have been possible.

This book, like any other, will be only as good as it is useful to those who read it. So to those people who do read it let me quote a passage from Kahlil Gibran's *The Prophet*, which says much better than I can what is in my heart and mind:

> Then said a teacher, Speak to us of Teaching.
> And he said:
>
> No man can reveal to you aught but that which already lies half asleep in the dreaming of your knowledge.
>
> The teacher who walks in the shadow of the temple, among his followers, gives not of his wisdom but rather of his faith and his lovingness.
>
> If he is indeed wise he does not bid you enter the house of his wisdom, but rather leads you to the threshold of your own mind.
>
> The astronomer may speak to you of his understanding of space, but he cannot give you his understanding.
>
> The musician may sing to you of the rhythm which is in all space but he cannot give you the ear which arrests the rhythm nor the voice that echoes it.
>
> And he who is versed in the science of numbers can tell of the regions of weight and measure, but he cannot conduct you thither.

For the vision of one man lends not its wings to another man.

And even as each one of you stands alone in God's knowledge, so must each one of you be alone in his knowledge of God and in his understanding of the earth.

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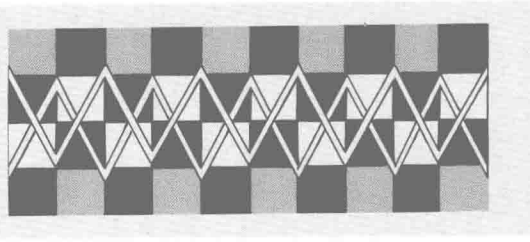
Chapter 1



PSYCHIATRIC NURSING

Patients are people in trouble, usually serious trouble when they come under the care of the nurse. They have often lost the ability to care for themselves, to meet their own needs, to live their own lives. They generally must depend upon somebody else for their very survival, for their most intimate personal needs, for their existence as individuals. The nurse may become that "somebody else" upon whom they depend for help. It is up to her, then, to provide a certain kind of relationship and a certain kind of environment that allows the patient to move in the direction of health.

Patients are looking essentially for two things when they come to the nurse for help: someone who really cares about them and someone who will be honest with them. This is particularly true of psychiatric patients, but it is true of other patients as well. Patients in an intensive care unit, who had come to one hospital with life-threatening illnesses, were asked what aspects of their treatment had made the biggest impression upon them. Do you know what the majority of them answered? Not the life-saving measures, not the efficiency of the staff, not the latest scientific breakthroughs, but the fact that the nursing staff *really cared about them.* When we are in trouble, that's what we look for—a person who really cares. Before you can put your trust in someone else, you have to feel the other person genuinely cares about you and will be honest with you. That is essential in establishing a trust relationship—the basis for successful nursing care.

Two major responsibilities of the nursing staff are the establishment of a therapeutic relationship with the individual patient and the establishment of a therapeutic environment for all patients. That means that everything we do as nurses must reflect two basic attitudes—caring and honesty. The routine ward schedule, the arrange-

ment of the furniture, and the serving of meals must reflect these attitudes. How we care for patients—what we say and how we say it, what we do and how we do it—tells the patient whether or not we care about him and determines whether or not our nursing care is therapeutic, effective, and helpful.

In caring for patients, the nurse goes through the steps of the nursing process: assessment, planning, implementation, and evaluation. In other words, she applies the problem-solving technique to her nursing care. In assessment, she identifies and assigns priorities to the patient's needs, taking into consideration his condition, his circumstances, and his ability to meet his own needs. Then, with the patient, she designs a nursing care plan, which outlines long and short range goals for the patient and the nursing actions or interventions that are needed to help the patient reach those goals. She puts that plan into effect by using her own healthy personality in a therapeutic manner to help the patient move in the direction of health. She documents the patient's response to her care and modifies her nursing actions according to the results of that evaluation. Thus, each patient's care is individualized and directed toward the resolution of his particular problems.

Psychiatric nursing is different from, yet similar to, all other kinds of nursing. Some people think of psychiatric nursing as being the basis, the heart, the core, the very art of nursing itself. Others think of psychiatric nursing as being strictly limited to the care of patients diagnosed as mentally ill. Psychiatric nursing is definitely not a neat set of procedures or rituals that ends with a cure. It is rather an arduous, personal, human struggle toward health.

It can be generally agreed that psychiatric nursing is a process of human communication which involves two people, one a nurse and the other a patient, and their relationship, the sum of their interactions with one another. The primary purpose of their relationship is to help the patient find greater satisfaction of his basic needs and more effective ways of behaving in order to obtain that satisfaction—in other words, to help the patient find greater success in living. Furthermore, it is the responsibility of the nurse to establish, maintain, and terminate such a relationship. Whether or not that relationship is therapeutic, helpful, or even healthy can be measured very simply by the sense of well-being that the patient experiences as a result of it.

Often the nurse who is beginning her study or practice of psychiatric nursing is influenced by commonly held misconceptions regarding mentally ill patients, their treatment, and the nurse's contribution to their care. As a result, she may look at and approach the care of psychiatric patients with attitudes,

feelings, and actions that are harmful rather than helpful. It is essential for the nurse to recognize, understand, and correct her approach if she is to deal therapeutically with the patient—all patients—and I believe all people. With this in mind, let us discuss some basic facts regarding the patient, the nurse, and their relationship, as well as mental illness and psychiatric treatment.

THE PATIENT

First of all, the patient is a person, a unique human being different from all others. He is not a category of illness, a kind of condition, or a set of symptoms. He is a person, an individual who is sick, in trouble, alone and afraid. He often becomes an alien, an outcast, a burden, a stranger in his own world, and may be met with fear, anger, suspicion, hostility, contempt, disgust, despair, or ridicule from those closest to him as well as those who don't even know him. When he can no longer tolerate the fear and loneliness, he turns to strangers for the love and acceptance he needs and he becomes a patient.

He is sick with a strange and frightening illness over which he has little or no control. He often knows inside himself that he shouldn't think and feel such things, let alone say or do them, but he can't seem to stop. He sees people look at him with fear or distrust, guilt or anger, disgust or embarrassment. He finds that things are getting worse for him instead of better, and he begins to experience an ever-increasing succession of failures and rejection. When he can no longer meet his own needs or direct his behavior appropriately, he seeks, by becoming a patient, to obtain comfort and relief from those who are prepared to help him.

THE NURSE

The nurse, too, is a person, a unique human being, different from all others. She is not a particular kind of personality, or set of attributes, or accumulation of special qualities. She is an individual, a product of her own life experiences, who has acquired specific knowledge and skills in caring for others. She has decided that her life's work will be spent in the service of others and she becomes a nurse.

She is a healthy adult, emotionally mature enough to be able to postpone the satisfaction of her own needs and allow the patient's needs to take precedence. She is able to tolerate frustration and stress effectively enough to handle her resulting feelings in constructive ways. She has sufficient self-awareness to appreciate the impact she has upon others, and she assumes re-

sponsibility for her behavior. She is flexible enough to be able to change and receptive enough to learn new ways of perceiving and responding to life. She is concerned about the welfare of others and does something about it by becoming a nurse.

THEIR RELATIONSHIP

The therapeutic relationship assumes that one person (the patient) is in need of and asking for help, and the other person (the nurse) is able and willing to give him that help. It consists of a series of interactions between these two people, nurse and patient, that leads them both in the direction of greater health and happiness. It is of necessity a human, individual, and very personal experience. I am convinced that one person cannot help another unless he cares enough about him to risk personal involvement and commitment, and unless he himself has experienced helpfulness in some way.

Too frequently we hear the nurse's comment, "I wish I had enough time to relate (or socialize or visit) with the patient." It may have something to do with the short length of time the nurse and patient are in direct contact. In these days of advanced medical science and technology, the time the patient is in the care of the nurse has been considerably shortened. Also, the nurse has many patients to care for, not just one, and treatment facilities are notoriously overcrowded.

But how long does it take to relate to another person? Sometimes a single look or touch initiates a deep and lasting relationship. At the same time, one can spend a lifetime with another person and never relate in more than the most superficial way. Many people who have shared a single crisis situation in life, such as occurs in war time, have established meaningful relationships that last a lifetime. Such a relationship is often described in current slang as "a happening," an event that is not based upon duration of contact, numbers of people, scientific principles, or even logic. It is based instead upon the underlying feelings of compassion, desire, need, and love for another human being. Certainly illness is a time of crisis for the patient and the proximity of the nurse puts her in an ideal spot for developing a supportive relationship.

The nurse relates with the patient in a single exchange or a series of interactions or in prolonged contact, but the relationship almost always involves something of a highly personal, critical, and important nature. In any single interaction the nurse either meets the patient's needs and adds to his feelings of comfort, security, and well-being or she does not. The way in which she re-

lates with the patient, then, is either helpful or harmful and it becomes the basis of her effectiveness as a nurse. A helpful relationship between nurse and patient can be characterized by its acceptance, honesty, understanding, and faith.

Acceptance. First of all, the relationship between nurse and patient must be an accepting one. That means that the nurse must be able to accept the patient, no matter what he says or does or where he comes from, not just because he is a patient, but because he is a person of essential worth and dignity, deserving of her love and respect. It does not mean that she must or should or even could approve of everything he does. She may have feelings of disapproval, dislike, even disgust for certain of his actions. It is necessary, however, that she be able to control and express her feelings in a constructive way, so as not to reject, punish, or ignore the patient. At the same time he needs to know what is expected, appropriate, acceptable behavior on his part, and he needs help in learning how to behave in such a fashion.

For example, if a patient repeatedly spits in the drinking fountain, it may be up to the nurse to let him know that this is not acceptable behavior, why it is not, and what he can do to correct it. It is not necessary to bawl him out, or send him to his room, or make fun of him in front of other patients. It may be that he cannot find the bathroom in order to spit in the toilet, or he thinks the fountain contains evil spirits that can only be kept in control if he spits on them.

Honesty. The relationship between nurse and patient must be an honest one. That means that the nurse must be genuinely concerned about the welfare of the patient and willing to help him do something about it. It means further that she must be certain that what she says and does in interaction with him agrees with and expresses that kind of human concern. There is no room for phoniness.

For example, a patient may continue to tease a nurse about her private life until she becomes angry. It is important to her relationship with the patient that she not deny that anger, but that she express it in such a way that she helps him understand how his behavior affects her and perhaps others and how he might change it. If she says in an angry voice, "I'm not angry," she has told the patient two things—not only that she is indeed angry but that she is also dishonest, which lessens her effectiveness in relating with the patient. How can he be expected to put his faith and trust in someone who cannot even admit that she is human enough to become angry?

On the other hand, it is important that the nurse not attach her feelings of frustration about other situations to her relationship with the patient. If she is angry with the doctor, or her husband,

or the afternoon shift, it should not be the patient who takes the brunt of it. It is, therefore, necessary for the nurse to understand her own motives, be able to face up to them, and direct them toward a constructive resolution. For example, if she has had a trying morning with a group of visitors, she should not be short or ill-tempered with the patient who asks for assistance from her; or if she is, she should apologize to him and explain the reasons for her inappropriate behavior.

Understanding. The relationship between nurse and patient must be one of understanding. That means that the nurse must know the individual patient well enough to be able to understand how *he* feels in the situation that he is in, not how *she* might feel, or how others have felt in similar situations. That is the difference between empathy on the one hand, and sympathy on the other. Empathy in psychiatric terms is one of the nonverbal ways the nurse uses to communicate her care and concern for the patient. She must do more than make assumptions about how he feels—she needs to check with him to be sure that is how he really feels.

For example, a patient may be scheduled to have visitors but they do not show up, and later the nurse finds him crying in his room. She might assume he is sad and lonely, and feels deserted by his family. However, if she were to check with him, she might find out that he is relieved that they did not come because he did not know how to explain to his little girl that he would not be home for her birthday.

Faith. The relationship between nurse and patient must be one of mutual faith. That means that the nurse must have faith in her ability to help the patient and his ability to respond to her. It means also that the patient must have sufficient faith in the nurse's competence that he can put himself in her care. It means further that these two people, nurse and patient, must have sufficient faith in one another to sustain them in times of difficulty. No human relationship exists without strife or strain, and that includes the therapeutic relationship. Both people must be able to rise above human frailty and to forgive and forget one another's shortcomings, not hold each other forever accountable for human error. It was Pope who said, "To err is human, to forgive, divine," but I like to think of both erring and forgiving as human characteristics, which are necessary for successful relationships.

For example, a patient may be making great strides toward recovery and then unaccountably begin to slip back into his illness. The nurse, in her disappointment, may reprimand him or avoid contact with him. In so doing, she has violated the essential element of faith in her relationship with the patient, and sold them