Psychiatric Nursing

Ns. Sutejo, S.Kep., M.Kep., Sp.Kep.J.

Editors:
Sri Warsini, S.Kep., Ns., M.Kes., Ph.D.
Dr. Deni Hardianto, M.Pd.
Adam Ansori, S.S., M.A.

Psychiatric Nursing

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Adam Anshori, S.S., M.A.

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PSYCHIATRIC NURSING

Sutejo

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Jl.Kaliurang Km.9,3 – Yogyakarta 55581
Telp/Faks: (0274) 4533427
Website: www.deepublish.co.id
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FOREWORD

Our foremost and utmost gratitude to God The Almighty, for His abundant grace that allowed us, Deepublish Publisher to publish this book entitled ***Psychiatric Nursing***.

As a publisher that–above other missions–prioritizes its role to educate and glorify mankind, as well as to utilize science and technology to its best, we do not only attend to the work of established writers, but we provide the room and facility for people who wish to express their creativity and innovation in writing and conveying ideas and values.

Our warmest gratitude and appreciation to the author, Ns. Sutejo, S.Kep., M.Kep., Sp.Kep.J., who has given us trust and contribution to the perfection of this book. Hopefully, this book is useful, and educative, and contributes well in glorifying mankind and the utilization of science and technology in the country.

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CHAPTER I
BASIC CONCEPTS OF PSYCHIATRIC NURSING

LEARNING OBJECTIVES

After studying this subject, students will be able to do the following:

1. Organizing the definition of mental health
2. Detecting the characteristics of mental health
3. Integrating the psychiatric nursing paradigm
4. Explain the philosophy of psychiatric nursing

INTRODUCTION

Humans as bio-psycho-socio-spiritual creatures contain the meaning that humans are complete beings in which there are biological elements, psychological, social, and spiritual. As biological creatures, humans are composed of millions living cells that will form a network, then the network will unite and form organs and organ systems. As a psychological creature, every human being has unique personality and has a personality structure consisting of id, ego, and super ego is equipped with intellect and intelligence, so that it can always be a person develop. Every human being also has psychological needs such as being spared psychological tension, need for intimacy and love, altruistic satisfaction (satisfaction to help others without expecting anything in return), honor and ego satisfaction.

Meanwhile, as social beings, humans cannot live alone, humans always want to live with others and need others. In addition, humans must cooperate with other human beings to meet the needs and demands of life. Humans are also required to be able to behave in accordance with expectations and norms what happens in the social environment. As spiritual beings, humans have belief and acknowledging the existence of God, have a view of life, the

encouragement of life that is in line with the religious nature he adheres.

A. DEFINITION OF MENTAL HEALTH

1. World Health Organization

   Mental health is a state of complete physical, social and mental well-being and not merely the absence of disease or disability. An individual is said to be mentally healthy if he is in a physical, mental and social condition that is free from disturbances (disease) or is not under pressure so that he can control the stress that arises. These conditions allow individuals to live productive lives, and are able to carry out satisfying social relationships.

2. Health Law Republic of Indonesia number 18 of 2014

   Mental health is a condition in which an individual can develop physically, mentally, spiritually and socially so that the individual is aware of his own abilities, can handle pressure, can work productively and is able to make a contribution to his community.

B. CHARACTERISTICS OF HEALTH

1. Yahoda

   Yahoda characterizes mental health as follows:

   a. Have a positive attitude towards yourself
   b. Grow, develop and actualize
   c. Recognizing the integration and relationship between: Past and present Having autonomy in decision making and not depending on anyone
   d. Have a perception in accordance with reality
   e. Able to master the environment and adapt

2. World Health Organization (WHO)

   In 1959 at a meeting in Geneva, WHO succeeded in formulating mental health criteria. WHO states that, a person

is said to have mental health, if he has the following criteria:

a. Individuals are able to adapt constructively to reality, even though reality is bad for them
b. Get satisfaction from the results of your hard work
c. It is more satisfying to give than to receive
d. Relatively free from tension (stress), anxiety and depression
e. Able to relate to others in a mutually helpful and mutually satisfying manner
f. Able to accept disappointment as a lesson to come
g. Have affection

In 1984, WHO added a religious dimension as one of the 4 pillars of mental health, namely: Holistic health, namely physical/physical (biological) health; mentally healthy (psychiatric/psychological); socially healthy; and spiritually healthy (spiritual/religious). Based on these four healthy dimensions, the American Psychiatric Association adopted the paradigm of the biopsycho-socio-spiritual approach. Where in the development of a person's personality has 4 holistic dimensions, namely religion, organobiology, psycho-education and socio-culture.

3. MASLOW

Maslow said that mentally healthy individuals have the following characteristics:

a. Accurate reality perception
b. Accept yourself, others and the environment
c. Spontaneous
d. Simple and reasonable

Based on the definition above, it can be concluded that a person is said to be mentally healthy if:

a. Comfortable with yourself

Able to overcome various feelings: anger, fear, anxiety, envy, guilt, pleasure, love, etc. and able to overcome

disappointment in life. Have reasonable self-esteem: assess yourself in a real way, neither belittle nor exaggerate, feel satisfied with everyday life)

b. Comfortable relating to others
   Able to love and receive love from others: has a stable personal relationship, is able to trust others (can respect the opinions of different people, feels part of a group, does not deceive others, and does not allow himself to be tricked by others).

4. Able to meet the needs of life
   Setting real life goals for himself (able to make decisions, accept responsibility, plan for the future, accept ideas/life experiences and feel satisfied with his job).

C. PARADIGM OF PSYCHIATRIC NURSING

Nurses must understand the nursing paradigm because studying the nursing paradigm will help a person or the wider community know and understand nursing and help understand every phenomenon. Based on the above understanding, the experts concluded that the purpose of the nursing paradigm is to regulate the relationship between various theories and conceptual models of nursing in order to develop conceptual models and theories as nursing frameworks.

Phenomenon is the client's behavior in dealing with the uncertainty of the conditions experienced due to discomfort resulting from the pain they are experiencing. The philosophy of nursing is a form of professional service which is an integral part of health services based on nursing knowledge and tips. In carrying out its roles and functions, a nurse must have confidence in the value of nursing as a guide in providing nursing care. The beliefs that a nurse must have are:

1. That humans are holistic beings consisting of bio-psycho-social and spiritual components

2. The aim of providing nursing care is to optimally improve the degree of human health
3. The nursing actions provided are collaborative actions between the health team, clients and families
4. The nursing action given is a problem-solving method with a nursing process approach
5. Nurses are responsible and accountable
6. Nursing education must be carried out continuously

1. Human

Mental nursing views humans as holistic beings consisting of bio-psycho-social and spiritual components which are a unified whole from the physical and spiritual aspects and are unique because they have various kinds of needs according to their level of development (Consortium of Health Sciences, 1992). Potter at al (2016) explains that humans are an open system, which always interacts with the external and internal environment so that balance (homeostasis) occurs. The nursing paradigm views humans as holistic beings, which are open systems, adaptive systems, personal and interpersonal. As an open system, humans are able to influence and be influenced by their environment, whether physical, biological, psychological or social and spiritual. As an adaptive system, humans will show adaptive or maladaptive responses to environmental changes. Adaptive responses occur when humans have good coping mechanisms in dealing with environmental changes, but if the ability to respond to environmental changes is low, then humans will show maladaptive behavior. Humans or clients can be interpreted as individuals, families or communities who receive nursing care.

2. Nursing

Nursing is a form of professional service as an integral part of health services which is carried out in a comprehensive manner in the form of biological, psychological, social, spiritual and cultural services, aimed at individuals, families and communities, both healthy and sick, covering the human life cycle. The provision of nursing care is carried out through a humanistic approach, namely respecting and respecting human dignity and upholding justice for all human beings. Nursing is universal, that is, in providing nursing care, a nurse never differentiates clients based on race, gender, age, skin color, ethnicity, religion, political ideology and social economic status. Nursing considers the client as an active partner, in the sense that the nurse always cooperates with the client in providing nursing care. Nursing care is a scientific method which in its administration uses a therapeutic process involving a cooperative relationship between the nurse and the client, and the community to achieve optimal health levels (Potter et al., 2016).

The nursing process helps nurses carry out nursing practice, in solving client nursing problems, or meeting client needs in a scientific, logical, systematic, and organized manner. Basically, the nursing process is a problem-solving technique. The nursing process is dynamic, cyclic, interdependent, flexible, and open. Through the nursing process, nurses can avoid routine and intuitive nursing actions. Through the nursing process, a nurse is able to meet the needs and solve client problems based on problem priorities so that nursing actions are in accordance with the client's condition, this happens because of the cooperation between the nurse and the client. In the early stages, the nurse as a provider of nursing care has a bigger role than the client's role, but in the later stages the client's role becomes

bigger than the nurse so that client independence can be achieved.

3. Health

Health is a dynamic state, in which individuals must be able to adapt to changes that occur, both changes in the internal and external environment to maintain their health status. Internal environmental factors are factors that come from within the individual that affect individual health such as psychological, intellectual and spiritual variables and disease processes. While external environmental factors are factors that are outside the individual can affect health, including physical environment variables, social and economic relations. One measure used to determine health status is the healthy/ill range. According to this model, health is constantly changing. Individual health conditions are always in the healthy/ill range, namely being between the two poles of optimal health and death. If the health status moves towards death, this means the individual is in a sick area, but if the health status moves towards being healthy then the individual is in a healthy area.

4. Environment

The environment in the context of nursing is an external factor that influences human development, namely the physical, psychological, social environment. culture, economic status, and spirituality. To achieve balance, humans must be able to develop effective coping strategies in order to adapt, so that interpersonal relationships that are developed can result in individual self-change.

D. PHILOSOPHY OF PSYCHIATRIC NURSING

Nursing philosophy is a basic view of human nature and the essence of nursing which forms the basic framework for nursing practice. Nursing philosophy aims to direct nursing activities carried out. Nursing views humans as holistic beings, so that the approach

to providing nursing care is carried out through a humanistic approach, in the sense that nurses really appreciate and respect human dignity, pay attention to clients and uphold justice for fellow human beings. Nursing is universal in the sense that in providing nursing care, nurses do not discriminate on race, gender, age, skin color, ethics, religion, political beliefs, and socioeconomic status.

SUMMARY

Individual who are productive and able to interact with the environment around must have a healthy soul. Individuals are said to be mentally healthy if they are in a physical, mental and social condition that is free from disturbance (illness), not deep stressful conditions so as to control the stress that arises. This condition will enable individuals to live productively, and be able to carry out social relations which is satisfying. In carrying out the role and function of a nurse in providing nursing care must view humans as bio-psycho-socio-spiritual creatures so that the selection of nursing models in implementing care nursing according to the paradigm of psychiatric nursing.

REVIEW QUESTIONS

1. Humans are one of the components in the principles of psychiatric nursing because?
   a. Every individual has self-esteem and dignity
   b. Mental problems can undermine all human functions
   c. Every individual has different needs
   d. Social beings who always act in interacting with the environment
   e. Has the same coping mechanism capacity in responding to stressors
2. Humans in dealing with the environment must be able to develop effective and adaptive coping strategies so that they are able to

a. Self-actualization
b. Adapt
c. Make decisions
d. Pursue life goals
e. Use yourself therapeutically

3. Which of the following is not a characteristic of mental health according to WHO?
   a. Helping each other
   b. Have affection
   c. Obtain satisfaction from his efforts
   d. Accept yourself, others and the environment
   e. Accept failure as a lesson for the future
4. Self-comfort is characterized by?
   a. Have reasonable self-esteem
   b. Able to cope with various feelings
   c. Achieve optimal self-actualization
   d. Able to adapt to the surrounding environment
   e. Able to overcome disappointment in life
5. The nursing philosophy is the cornerstone of nurses' understanding of healthy-ill humans who are unique and individualistic and have the ability to?
   a. Respond to a situation
   b. Respond negatively and positively
   c. Provides logical reasons rather than empirical methods
   d. Describe the study of causes and laws that underlie reality
   e. Adapt to the socio-economic environment and relative experience

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CHAPTER II
APPLICATION OF THE CONCEPTUAL MODEL OF PSCHIATRIC NURSING

LEARNING OBJECTIVES

After studying this subject, students will be able to do the following:

1. Organizing the definition of a conceptual model
2. Integrating the psychoanalytic conceptual model
3. Integrating the interpersonal conceptual model
4. Integrating the social conceptual model
5. Integrating the existential conceptual model
6. Integrating the supportive therapy conceptual model
7. Integrating the behavior conceptual model
8. Integrating the adaptation stress conceptual model
9. Integrating the medical conceptual model
10. Integrating the communication conceptual model
11. Integrating the nursing conceptual model

INTRODUCTION

Health-illness and adaptation-maladaptation are different concepts. Each concept is on a separate range. The healthy range of illness comes from a medical point of view while adaptation-maladaptation comes from a nursing point of view. Someone who experiences pain both physically and mentally can adapt to the state of his illness. Conversely, someone who is not diagnosed with illness may have a maladaptive coping response. These two ranges describe complementary models of nursing and medical practice.

A. DEFINITION

The conceptual model provides regularity for thinking, observing and interpreting what is seen, provides research directions to identify a question to answer phenomena and demonstrates problem solving (Christensen & Kenny, 2009). The nursing conceptual model is a way of looking at situations and conditions of work that involve nurses in it. The nursing conceptual model is a guide for nurses to get information so that nurses are sensitive to what is happening at a time and know what nurses have to do (Brockopp, 1999). Marriner-Tomey & Alligood (2006) explained that the conceptual model of nursing has clarified the specificity of the phenomenal area of nursing science by involving four concepts, namely the human being as a whole and unique person. The second concept is the environment which is not only the initial source of problems but also a source of support for individuals. The third is Health, explaining the range of health-illness throughout the cycle from conception to death. The fourth concept is nursing as an important component in its role as a determining factor in increasing the balance of one's life (client). Tomey further said that the conceptualization of nursing generally views humans as biopsychosocial beings who interact with their families, communities, and other groups, including their physical environment. The point of view and focus of emphasis on the conceptual scheme of each scientist can be different from one another, such as the emphasis on human adaptive systems, behavioral subsystems or complementary aspects. The purpose of the nursing conceptual model

1. Maintain consistency in providing nursing care
2. Reducing conflict, overlap, and void in the implementation of nursing care by the nursing team
3. Creating independence in providing nursing care
4. Provide guidelines in determining policies and decisions
5. Clearly define the scope and goals of nursing care for each

member of the nursing team

B. PSYCHOANALYTIC CONCEPTUAL MODEL

This is the model proposed by Sigmund Freud. Psychoanalysts believe that behavioral deviations in adulthood are related to development in childhood. According to the psychoanalytical model, mental disorders are caused by the ego not functioning in controlling the id, thus encouraging behavioral deviations and intrapsychic conflicts, especially during childhood. Each phase of development has a development task that must be achieved. Symptoms are symbols of conflict. The process of psychoanalytic therapy takes a long time. The therapy process in this model uses the free association method and transferent dream analysis, aiming to repair past trauma. An example of the therapeutic process in this model is: the client is put into a very deep sleep state. In a helpless state the therapist will explore the client's subconscious with various questions about past traumatic experiences. In this way, the client will express all his thoughts and dreams, while the therapist tries to interpret the patient's thoughts and dreams. The role of the nurse in the psychoanalytic model Conduct an assessment of traumatic conditions or stressors that are considered significant in the past, for example (becoming a victim of physical, social, emotional or sexual violence) using a therapeutic communication approach.

C. INTERPERSONAL CONCEPTUAL MODEL

This model was developed by Harry Stack Sullivan and Hildegard Peplau. Interpersonal theory believes that behavior develops from interpersonal relationships. Sullivan emphasized the enormous influence childhood development has on an individual's mental health. According to the concept of this model, a person's mental disorder is caused by a threat that can cause anxiety. Anxiety experienced by a person arises from conflict when dealing

with other people (interpersonal), due to fear and rejection or not being accepted by those around him. Sullivan said that individuals perceive other people according to what is in them and within the individual there are two drives, namely: the drive for satisfaction, related to basic needs such as: hunger, sleep, loneliness and lust as well as the drive for security.

The therapy process is divided into two components, namely building feeling of security (trying to build a sense of security in the client) and trusting relationship and interpersonal satisfaction (establishing a relationship of mutual trust). The principle of this therapy is to correct interpersonal experiences by establishing healthy relationships. With re-education it is hoped that clients will learn to build satisfying interpersonal relationships, develop relationships of mutual trust, and foster satisfaction in associating with other people so that clients feel valued and respected. The role of the nurse in therapy is share anxieties (sharing experiences about what the client feels and what causes the client's anxiety when dealing with other people) and therapist use empathy and relationship (empathy and sharing what the client feels).

D. SOCIAL CONCEPTUAL MODEL

This model focuses on the physical environment and social situations that can cause stress and trigger mental disorders (social and environmental factors create stress, which cause anxiety and symptoms). According to Scasz, each individual is responsible for his behavior, able to control and adjust behavior according to the values or culture expected by society. Kaplan believes that the concepts of primary, secondary and tertiary prevention are very important to prevent mental disorders from occurring. Social situations that can cause mental disorders are poverty, low levels of education, lack of support systems and coping mechanisms that are mal adaptive. The principle of the therapeutic process which is very important in the modification of the environment and the existence

of a support system. The therapy process is carried out by exploring the client's support system such as: spouse, family or friends. In addition, the therapist seeks to: explore the client's social system such as the atmosphere at home, office, school, community or workplace.

E. EXISTENTIAL CONCEPTUAL MODEL

The existential model developed by Ellis and Rogers states that behavioral disorders or mental disorders occur when individuals fail to find their identity and purpose in life. The individual has no pride in himself. Self-loathing and experiencing disturbances in body image. The principle of therapy in this model is to strive for individuals to have experience interacting with people who are role models or successful by understanding the person's life history, expanding self-awareness by means of self-introspection (self-assessment), associating with social and humanitarian groups (conducted in groups), as well as encouraging self-acceptance and receiving criticism or feedback about their behavior from others (encouraged to accept self and control behavior).

F. SUPPORTIVE THERAPY CONCEPTUAL MODEL

Wermond and Rockland's theory believes that the cause of mental disorders is biopsychosocial factors and current maladaptive responses. Examples of biological aspects are often sick with indigestion, migraines, coughs. The psychological aspect experiences many complaints such as: easily anxious, lack of self-confidence, feelings of guilt, doubt, anger. Social aspects such as difficulty getting along, withdrawing, disliked, hostile, unable to get a job, and so on. All of these things accumulate to cause mental disorders. This phenomenon arises due to the inability to adapt to problems that arise at this time and have nothing to do with the past. The principle of the therapeutic process in the supportive model is to strengthen adaptive coping responses. The therapist helps the

client to identify and recognize the client's strengths or abilities as well as coping, evaluate which abilities can be used for alternative problem solving. The therapist seeks to establish a warm and empathetic relationship with the client to help the client find adaptive client coping.

G. MEDICAL CONCEPTUAL MODEL

According Meyer and Kraeplin theory, the causes of mental disorders are complex multifactors, namely physical, genetic, environmental and social factors. The medical model believes that behavioral disorders are a manifestation of central nervous system (CNS) disorders. It is suspected that depression and schizophrenia are affected by the transmission of neural impulses, as well as synaptic disorders. So that the focus of management must be complete through diagnostic examinations, somatic therapy, pharmacology and interpersonal techniques. The nurse's role in this medical model is to collaborate with the medical team in carrying out diagnostic procedures and long-term therapy, the therapist's role is in providing therapy, reporting on the impact of therapy, determining diagnoses, and determining the type of therapeutic approach used. The medical model continues to scientifically explore the causes of mental disorders.

H. COMMUNICATION CONCEPTUAL MODEL

The behavioral model says that behavioral deviations occur if the message conveyed is not clear. Communication deviations regarding verbal and non-verbal, body position, speed and volume of voice or speech. The therapeutic process in this model includes: 1) Providing feedback and clarifying problems. 2) Provide reinforcement for effective communication. 3) Provide alternative corrections for ineffective communication. 4) Analyze the interaction process.

I. BEHAVIOR CONCEPTUAL MODEL

Eysenck, Wilpe and Skinner theory believes that behavior modification therapy was developed from learning theory. Learning occurs when there is a stimulus and a response arises, and the response is strengthened (reinforcement). Therapeutic process: Behavior model therapy is carried out by means of 1) Desensitization and relaxation, which can be done simultaneously. With this technique it is expected that the client's anxiety level will decrease, 2) Assertive training is learning to express something clearly and clearly without offending other people, 3) Positive training. Encourage and reinforce newly learned positive behavior based on pleasurable experiences for use in future behavior, 4) Self-regulation. Do it with the following steps. First train a set of behavioral standards that must be achieved by the client. Furthermore, the client is asked to carry out self-observation and self-evaluation of the behavior displayed. The final step is that the client is asked to provide reinforcement for the appropriate behavior.

J. ADAPTATION STRESS CONCEPTUAL MODEL

Nursing is a scientific discipline and this knowledge is the basis for carrying out nursing practice (Roy, 1983). More specifically, this theory argues that nursing as a science and practice plays a role in increasing individual and group adaptation to health so that attitudes that emerge are more positive. Nursing provides improvements to humans as a unified whole to adapt to changes that occur in the environment and respond to internal stimuli that affect adaptation. If a stressor occurs and the individual cannot use "coping" effectively then the individual needs treatment. The goal of nursing is to improve individual interaction with the environment, so that adaptation in every aspect increases. Components of adaptation include physiological functions, self-concept, role function, and interdependence. Adaptation is a central

component in the nursing model. In it describes the human as an adaptive system.

Adaptation describes the process of coping with stressors and the final product of coping. The adaptation process includes a holistic function aimed at positively affecting health which will ultimately improve integrity. The adaptation process includes the process of human interaction with the environment which consists of two processes. The first part of this process begins with changes in the internal and external environment that require a response. These changes in Roy's adaptation model are described as stressors or focal stimuli and are mediated by contextual and residual factors. Stressors produce interactions that are usually called stress. The second part is coping mechanisms that are stimulated to produce adaptive and ineffective responses. The adaptation product is the result of the adaptation process and is described in terms of conditions that enhance human goals which include: survival, growth, reproduction and mastery which is called integrity. This final condition is a dynamic equilibrium condition which includes increasing and decreasing responses. Each new adaptation condition is influenced by other adaptations, so that human dynamic equilibrium is at a higher level. The large distance from the stimulus can be attributed to the success of humans as an adaptive system. So increased adaptation leads to higher levels of well-being or health.

K. NURSING CONCEPTUAL MODEL

The nursing model approach is a conceptual model used in providing nursing care using a nursing process approach, holistically, bio, psycho, social and spiritual. The focus of treatment in the nursing model is behavioral deviation, nursing care focuses on individual responses to actual and potential health problems, by focusing on: the healthy range of illness based on basic nursing theory with specific nursing action interventions and evaluating the

results of nursing actions. This model adopts various theories including systems theory, development theory and interaction theory.

SUMMARY

The conceptual model provides an order for thinking, observing and interpret what is seen, provide research directions to identify something questions to answer phenomena and demonstrate problem solving. The purpose of the nursing conceptual model: maintain consistency in providing nursing care., reducing conflicts, overlapping, and voids in the implementation of care

care by the nursing team., creating independence in providing nursing care, provide guidelines in determining policies and decisions, clearly define the scope and goals of nursing care each member of the nursing team.

REVIEW QUESTIONS

Comparing the differences between medical and nursing conceptual models and why this happens?

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CHAPTER III

NURSING CARE IN PATIENT WITH ANXIETY DISORDERS

LEARNING OBJECTIVES

After studying this subject, students will be able to do the following:

1. Organizing the definition of anxiety disorders
2. Constructing the process of problem of anxiety disorders
3. Planning nursing care in patient with anxiety disorders

INTRODUCTION

Anxiety is a condition that often escapes the attention of nurses as a psychosocial problem. Patients often come to health services with recurrent physical complaints and claim that there is no improvement. This condition, if not handled properly, can interfere with the patient's daily activities. Therefore, anxiety nursing care needs to be known by nurses so that they can help patients and their families in dealing with anxiety. Anxiety nursing care consists of assessment, nursing diagnosis, nursing actions for patients and families (caregiver), evaluating the ability of patients and families (caregiver).

A. DEFINITION

Anxiety is a feeling of anxiety, worry or discomfort as if something will happen that is felt as a threat. This means that anxiety is closely related to feelings of uncertainty and helplessness. Anxiety is different from fear. Fear is an intellectual judgment of something dangerous, while anxiety is an emotional response to that judgment.

Based on the level of anxiety consists of: mild anxiety, moderate, severe and panic.

1. **Mild Anxiety**

   Mild anxiety relates to tension in everyday life and causes a person to be alert and increase his perceptual field (Videbeck, 2008). Anxiety motivates learning and generates growth and creativity. During this stage, a person becomes more alert and keenly aware of his environment. This type of anxiety can provide learning motivation and generate growth and creativity.

2. **Moderate Anxiety**

   At this level, the individual focuses on what is important and overrides the others. This anxiety narrows the field of individual perception. Individuals do not have selective attention, the ability to see, hear, and smell decreases (Stuart, 2016). If directed to do something, the individual can focus more attention.

3. **Severe Anxiety**

   At the level of severe field anxiety, individual perceptions are very narrow (Videbeck, 2008) and tend to focus on something detailed and specific and not think about anything else. All behavior is aimed at reducing tension. The individual needs a lot of direction to focus on other areas. A person’s perceptual ability decreases markedly and his attention is fragmented. His mind only focused on one thing and didn’t think about anything else.

4. **Panic Level**

   Panic is a loss of control; the individual is unable to do something even with directions. Panic results in personality disorganization and causes increased motor activity, decreased ability to relate to others, distorted perceptions and loss of rational thinking. If this level of anxiety continues for a long time, fatigue and death can occur (Videbeck, 2008). Symptoms that occur are palpitations, chest pain, nausea or vomiting, fear of losing control, paresthesias, body feeling hot

or cold (Stuart, 2016).

B. THE PROCESS OF PROBLEMS

The process of occurrence of anxiety includes stressors from predisposing factors and precipitation,

1. Predisposing Factors

Things that can affect the occurrence of anxiety, include:

a. Biological Factors
   Biological factors associated with a family history of anxiety.
b. Psychological Factors
   Anxiety patients have lost love and attention in childhood, low self-esteem, trauma of growing up (loss, separation).
c. Socio-cultural factors
   Socio-cultural factors related to anxiety include inadequate interpersonal relationships in infancy, low communication skills.

2. Precipitation Factor

Anxiety precipitating factors include:

a. Biology: disease
b. Psychological: threats to identity, self-esteem, self-integrity, loss of significant others, divorce.
c. Socio-cultural: changes in employment status, changes in functions and roles, environment, social.

C. SIGNS AND SYMPTOMS

Signs and symptoms of anxiety can be assessed from patient expressions and supported by interview and observation data.

1. Subjective data:
   Patient expresses about: worry, fear that something will happen
2. Objective data:

Cognitive	Emotion	Physique	Behavior	Social
Lack of attention	Easily offended	Decreased appetite	Nervous Physical	Sometimes avoiding

Cognitive	Emotion	Physique	Behavior	Social
Lack of concentration Misjudgment Impaired memory (forgetfulness) Blocking Perceptual field decreases Confused Passed speech	Waiting anxiety Nervous Tense Afraid Frustrated	Heart pounding Rapid breathing Cold sweats Difficulty sleeping	strain Tremors Flustered Quick Speak Lack of Coordination	contact with other people/social Social activity decreased Occasionally shows hostility

D. NURSING PROCESS IN ANXIETY DISORDERS

1. **Assessment**

   The assessment was carried out by interviewing and observing patients and their families (caregiver). The interview was conducted as follows: “How are you feeling right now? “. The nurse during the interview and at the same time observes the patient’s behavior. Identify the patient’s level of anxiety: mild, moderate, severe or panic. If you panic, immediately refer to the general hospital or psychiatric hospital.

2. **Nursing Diagnosis**

   After conducting the assessment, the nurse can formulate a nursing diagnosis based on the level of anxiety. Based on the data obtained, a nursing diagnosis is determined: anxiety.

3. **Nursing Plan in Anxiety Disorders**

   Anxiety nursing actions are performed on patients and families. The nurse builds a trusting relationship with the patient, asks about the physical complaints they experience, performs a physical examination and vital signs, explores the causes of physical complaints, assesses anxiety, identifies family problems in caring for, determines the level of anxiety,

formulates a diagnosis, trains ways to deal with anxiety in patients and families. The patient goes to the pharmacy to pick up the medicine, returns to the nurse, the nurse explains about the medicine to the patient and family and the tasks that the family needs to do, namely to guide the patient in practicing the skills to deal with anxiety that have been taught by the nurse.

At each meeting, nurses perform nursing actions for patients and families.

a. **Nursing Plan for Anxiety Patients**

Objective:

The goal of nursing action in patients with anxiety is that the patient is able to:

1) Recognize anxiety
2) Implement ways to overcome anxiety:
   a) Ways of verbal, auditory and behavioral distraction
   b) Deep breath relaxation
   c) Five finger hypnosis
   d) Spiritual way
   e) Obediently take medication

Nursing actions:

1) Help patients recognize anxiety by:
   a) Help patient identify and express feelings
   b) Help the patient describe situations that cause anxiety
   c) Help the patient identify the causes of anxiety
   d) Help the patient recognize anxiety-related behaviors
2) Train the patient to relax deep breaths
   a) Sitting position on the floor or chair with the body relaxed and no pressure on the muscles that impede blood flow
   b) Inhale through your nose very slowly
   c) Blow through your mouth very slowly.
   d) Blow while deflating the stomach

e) Do it repeatedly
f) Eyes may be opened or closed

3) Practice controlling anxiety with distraction
   a) See the natural scenery of the coast or mountains (visual distraction)
   b) Hearing nature sounds such as running water, birds singing, instrumental music or soft music (audio distraction)
   c) Instruct the patient to do activities such as watching movies, comedies, cartoons, reading novels, reading words in reverse, chewing gum, looking at objects around, bringing two fingers as close as possible repeatedly.
   d) Talking to other people you trust (social)
4) Train the patient to control anxiety with five finger hypnosis
   a) Sit or lie down with your eyes closed and your body relaxed. Mind emptied.
   b) Touch thumb with forefinger. Start imagining you are exercising and have a healthy body
   c) Touch your thumb with your middle finger. Start imagining that you are meeting someone you like and have a close relationship with
   d) Touch your thumb with your ring finger. Start imagining when you get compliments and have the ability to be proud of
   e) Touch the thumb with the little finger. Start imagining beautiful natural scenery and being there.
5) Train patients to overcome anxiety in a spiritual way
   a) Discuss the beliefs held by the patient
   b) Practice how to control anxiety according to the patient's beliefs
   c) Motivate the patient to do so

6) Train patients to manage anxiety with drug adherence
    a) Explain about the 5 right principles of taking medicine
    b) Explain the benefits of the drug
    c) Explain the importance of taking regular medication
    d) Explain the importance of continuity in taking medication

b. Nursing actions for families of anxiety patients

Families are expected to be able to care for anxiety patients and become an effective support system for patients.

Objective:

Families can afford:

a) Recognize anxiety problems
b) Deciding the services needed by the patient with anxiety
c) Caring for anxiety patients
d) Create a family atmosphere and a safe environment.
e) Monitor and guide patients in dealing with anxiety
f) Follow-up to health care facilities on a regular basis

Nursing actions

1) Discuss the perceived problems in caring for the patient
2) Explain the meaning, signs and symptoms, the process of anxiety occurrence and how to treat patients.
3) Train families to create a family atmosphere and a supportive environment

4. **Evaluation**

To measure the success of your nursing care, you can do this by assessing the ability of the patient and family:

a. Patient ability:

1) Build a trusting relationship
2) Get to know anxiety
3) Mention ways to overcome anxiety with relaxation techniques
4) Implement 4 ways of relaxation techniques

b. **Family capability:**
    1) Be able to mention the meaning, signs and symptoms and causes of anxiety
    2) Mention how to care for patients with anxiety
    3) Able to train patients 4 (four) ways to control anxiety
    4) Able to use health service facilities

SUMMARY

Anxiety is confusion, fear of what something will happen to unexplained cause associated with feelings of uncertainty and helpless. Anxiety has a value that positive because the individual will develop because of the attitude of confrontation (opposition), high anticipation, use of knowledge and attitudes towards anxiety coping experience. But in an advanced state of anxiety can interfere with someone's life. Anxiety is divided into three levels, namely mild, moderate, severe and panic. Mild anxiety is characterized by tension in everyday life, cause a person to be alert, increase the field of perception (perception widespread), increased motivation and creativity, able to learn and solve problems effectively. While the signs and symptoms of moderate anxiety are receiving external stimuli decreased, very concerned about the thing that became the center of his attention, the field perception narrows, and learns with the direction of others. In severe anxiety, it is characterized by a very narrow perceptual field, center attention to small (specific) details and unable to think about other things. The behavior aims to ask for help, and requires direction more to focus on other areas. In panic, there will be signs and symptoms of individuals who are very confused, unable to act, communicate, and function effectively, motor activity increases, the ability to relate to others is greatly reduced, the individual cannot do things without direction, and unable to think rationally.

REVIEW QUESTIONS

1. The results of the study found that activity data were very lethargic, not passionate, not passionate eat, can't sleep and often wake up and often ask about. The disease is based on the results of a physical examination of blood pressure, respiration rate and pulse increase. Based on the data above, the client experiences?
   a. Anxiety
   b. Fear
   c. Body image disorder
   d. Lost
   e. Grieving
2. The results of the examination show that the patient's perception data is very narrow and only capable focus attention on the events that are being experienced. Based on the data above, the patient anxiety level
   a. Light
   b. Moderate
   c. Weight
   d. Panic
   e. Shock
3. Nursing actions performed by nurses in dealing with anxiety except for?
   a. Reducing patient anxiety
   b. The patient can recognize anxiety
   c. The patient can overcome anxiety through relaxation exercises
   d. The patient can demonstrate and use relaxation exercises to overcome anxiety
   e. Do not involve the family in the exercises that have been prepared
4. Nursing actions in patients experiencing anxiety are except?
   a. Help relate situations and interactions that cause anxiety.

b. Helping to make an assessment of stressors that are felt to be threatening and cause conflict.
c. Help link current experience with past experience
d. Provide support so that anxiety decreases
e. Increased anxiety

5. The following are physiological responses of anxious patients except?
    a. Vibrating sound
    b. Shaking or shaking hands.
    c. Increased sweating
    d. Stressed face
    e. Fear

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CHAPTER IV
NURSING CARE IN PATIENT WITH BODY IMAGE DISORDERS

LEARNING OBJECTIVES

After studying this subject, students will be able to do the following:

1. Organizing the definition of body image disorder
2. Constructing the process of body image disorders
3. Planning nursing care in patient with body image disorders

INTRODUCTION

Body image includes an individual's attitude towards his own body, including physical appearance, structure and function. Body image is the image a person has in their minds about appearance of the body and the attitude formed by a person about the changes in his body. So this body image has two components namely components of how one perceives one's body and attitude component about how one feels about one's appearance or body which is perceived. Body image is a view or perception of oneself, isn't it other people's evaluation of him. A person's attitude towards his body can conscious and unconscious includes the perception of feelings about size and shape current function, appearance and potential of the body. Self-image is closely related with personality, the way individuals see themselves has an impact on aspects psychologically, individuals who have a realistic view of themselves, accept, liking body parts will give you a sense of security, confidence and avoidance anxiety and besides that it can increase self-esteem.

DEFINITION

According to Stuart and Laraia (2005) that body image is a collection of conscious and unconscious individual attitudes towards their bodies. Included in this are perceptions about the past and present, as well as feelings about size, function, appearance and self-potential. Body image is one component of self-concept where self-concept is all the thoughts, beliefs and beliefs that make a person know about himself and affect relationships with other people. Another view of the body's mind is one's conscious and unconscious attitude towards one's body including perceptions and feelings about the size and shape, function, appearance and potential of the body's present and past. Meanwhile, Keliat, et al. (2019), define body image as attitudes, perceptions, beliefs, individual knowledge consciously or unconsciously towards their bodies, namely size, shape, structure, function, limitations, meaning and objects that are in continuous contact (earrings, make-ups, contact lenses, clothing, wheelchairs) both past and present.

CLINICAL MANIFESTATIONS

Patients with disturbed body image can be identified if they show signs and symptoms as follows: a. Refusal to see and touch body parts that change

a. Do not accept changes in the body that have occurred/will occur
b. Refusing to explain body changes
c. Negative perception of the body
d. Preoccupation with missing body parts
e. Expressing despair
f. Reveals fear.

ASSESSMENT

Assessment of patients with body image disorders is carried out by means of interviews and observation. The following are observations during the assessment that you must do.

1. Signs and Symptoms:

   Observable Objective Data:

   a. Changes and loss of limbs, both structure, form and function
   b. Hiding or showing off the affected body part
   c. Refusing to look at body parts
   d. Refusing to touch body parts
   f. Decreased social activity.

   Subjective Data: Subjective data obtained from interviews, patients with body image disorders usually express:

   a. Rejection of:
      1) Changes in current limbs, for example dissatisfaction with the results of surgery
      2) Impaired limbs
      3) Interaction with other people
   b. Feelings of helplessness, worthlessness and hopelessness
   c. Desire that is too high for the affected body part
   d. Often repeats about the loss that happened
   e. Feeling foreign to missing body parts.

The next step that must be done after conducting the assessment is to group the data and conduct data analysis.

NURSING DIAGNOSIS

The nursing diagnosis is body image disorders

NURSING INTERVENTION

Nursing actions for patients with body image disorders aim to enable patients to:

1. Identify their body image.
2. Increase acceptance of their body image.

3. Identify positive aspects of self.
4. Know ways to improve body image.
5. Perform ways to improve body image.
6. Interact with others without being disturbed.

In order for the goal of providing nursing care for patients with body image disorders to be successful, the nursing actions taken are:

1. Discuss the patient's perception of his body image, past and present, feelings about his body image and expectations about his current body image.
2. Motivate the patient to see/ask for help from family and nurses to see and touch body parts gradually.
3. Discuss positive aspects of self.
4. Help the patient to improve the function of the affected part of the body (for example using an artificial anus from a colostomy).
5. Teach patients improve body image by:
   a. Patient motivation to carry out activities that lead to the formation of an ideal body
   b. Use a prosthesis, wig, cosmetics or something else as soon as possible, wear new clothes.
   c. Motivate the patient to see the missing parts gradually.
   d. Help the patient touch the area.
6. Interact gradually by:
   a. Arrange a schedule of daily activities
   b. Motivation to carry out daily activities and be involved in family and social activities
   c. Motivation to visit friends or other people who are meaningful or have an important role for him d. Give praise for the patient's success in interacting

1. Actions on the family

General objectives: The family can help increase client confidence

Specific goals:

a. Families can recognize the problem of body image disturbance
b. Families can recognize the problem of body image disturbance
c. Families know how to deal with body image disturbance problems
d. Families are able to treat patients with body image disorders.
f. Families are able to evaluate the patient’s abilities and give praise for their success.

2. Nursing actions

a. Explain to the family about body image disturbances that occur in patients.
b. Explain to the family how to deal with body image disturbances.
d. Teach the family how to care for the patient.
e. Provide facilities to meet the needs of patients at home.
f. Facilitate interaction at home.
g. Carry out home and social activities.
h. Give praise for patient success.

NURSING EVALUATION

a. Expresses perceptions of body image, past and present
b. Express feelings about body image and expectations about current body image
c. Ask for help from family and nurses to see and touch body parts gradually
d. Discuss positive aspects of self
e. The patient asks to improve the function of the affected body part (e.g., using an artificial anus from a colostomy).

SUMMARY

Body image is one component of self-concept where self-concept is all the thoughts, beliefs and beliefs that make a person know about himself and affect his relationships with other people. Objective data that can be observed in patients with disturbed body image are changes and loss of body parts, both structure, shape and function, hiding or showing disturbed body parts, refusing to see body parts, refusing to touch body parts, decreased social activity. Subjective data expressed by patients with body image disturbances is to express resistance to changes in current limbs, for example dissatisfaction with the results of surgery, limbs that are not functioning. Refusing interaction with others, and expressing feelings of helplessness, worthlessness and hopelessness. Expresses excessive desire for the affected body part. Often repeats the loss that occurred. Feeling alien to the missing body part. Assessment is the initial stage and the main basis of the mental health nursing process which consists of collecting data and formulating needs with an approach using therapeutic communication techniques. Based on the data collected, both subjective data and objective data, then the problem is formulated, carrying out nursing actions according to the action plan, evaluating the success of the client and family.

REVIEW QUESTIONS

Analyze the process of body image disorders and interventions that can be done for patients and their families!

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CHAPTER V
NURSING CARE IN PATIENT WITH LOSS

LEARNING OBJECTIVES

After studying this subject, students will be able to do the following:

1. Organizing the definition of loss
2. Constructing the process of problem of loss
3. Planning nursing care in patient with loss

INTRODUCTION

Loss is a condition that is disconnected or separated or start something with no meaning since the incident. Loss may occur gradually or suddenly, can be without violent or traumatic, anticipated or unexpected, partial or total and may return or may not return. Losing is the state of the individual parting with something what previously existed becomes non-existent, either partially or completely. Loss is an experience that every individual has experienced during the life span, since birth the individual has experienced lose and tend to experience it again, even though it is deep different shape

DEFINITION

Loss is an individual's state of being separated from something that previously existed, the possibility of it becoming non-existent, whether it occurs in part or in whole. Factors that affect the reaction to loss, depending on:

a. The meaning of loss
b. Social culture
c. Belief/spiritual
d. Role of sex/gender
e. Socioeconomic status

b. Physical and psychological condition of the individual.

Types of Losses are divided into 2 types, namely:

a. Actual or real loss. This loss is very easily recognized or identified by others, such as the loss of a limb, amputation, the death of a very meaningful/loved person.
b. Loss of perception. This type of loss is only experienced by a person and is difficult to prove, for example; someone who stops working/laid off, causing feelings of independence and freedom to decrease.

TYPES OF LOSS

a. Losing someone who is loved, and very meaningful or someone who means is one of the most disturbing types of loss of the types of loss. Death will have an impact on the loss of loved ones. Because of the loss of intimacy, intensity and dependency from existing bonds or relationships, the death of a spouse or child usually has a tremendous emotional impact that cannot be covered.
b. Loss that is in oneself (loss of self)
   Another form of loss is loss of self or perceptions about one's mentality. This loss includes loss of feelings of attractiveness, self, loss of physical and mental abilities, and loss of role in life, and its impact. Loss of this aspect of the self may be temporary or permanent, partial or complete. Some other aspects that can be lost from a person for example loss of hearing, memory, youth, bodily functions.
c. Loss of external object
   Loss of external object e.g., loss of personal or shared property, jewelry, money or job. The depth of grief one feels for a lost object depends on its meaning and use.

d. Loss of a very familiar environment
   Loss is defined as the separation of individuals from very familiar environments including from family background life in one period or alternately sedentary. For example, moving to another city, you will have new neighbors and a new adjustment process.
e. Loss of life/death
   A person can experience death both in feelings, thoughts and responses to activities and people around him, up to actual death. Some people respond differently to death.

LOSS RESPONSE RANGE

Denial ––> Anger ––> Bargaining –––> Depression ––– > Acceptance

a. Denial phase
   - The first reaction in this phase is shock, not believing in reality
   - Verbal expressions in this phase are usually the individual saying it's impossible, — I don't believe it happened.
   - Physical changes; tired, weak, pale, nausea, diarrhea, respiratory problems, fast heartbeat, crying, restlessness.
b. The anger/anger phase
   - The individual begins to realize the reality that is happening
   - An angry response arises projected on others
   - The physical reactions that arise are; red face, rapid pulse, restlessness, insomnia, clenched fists, and aggressive behavior.
c. The betting/bargaining phase.
   - Verbal expressions in this phase are; why should this happen to me?, if only it wasn't me who was sick, if only I had been careful.

d. Depressive phase

- Shows withdrawn attitude, doesn't want to talk or is hopeless.
- Symptoms in this phase the individual refuses to eat, complains of difficulty sleeping, fatigue, decreased libido drive.

e. Acceptance phase

- Thoughts on the lost object begin to diminish.
- The verbal expression in this phase is "what can I do so that I can get well soon, well, finally I have to have surgery"

SIGNS AND SYMPTOMS

Symptoms that arise in patients with loss include:

a. Unsuccessful adaptation to loss
c. Depression, prolonged denial
d. Slow emotional reactions
e. Unable to accept normal life patterns

Signs that may be found in patients with loss include:

a. Social isolation or withdrawal
b. Failing to develop new relationships/interests
c. Failed to rebuild life after loss

ASSESSMENT

The results of the study obtained data, namely:

a. Sad feelings, crying
b. Feelings of hopelessness, loneliness
c. Denying loss
d. Difficulty expressing feelings
e. Decreased concentration
f. Excessive anger
g. Not interested in interacting with other people
h. Excessive rumination of guilt
i. Slow emotional reactions

j. Changes in eating habits, sleep patterns, activity levels.

NURSING DIAGNOSES

After you have analyzed the data and formulated the problem, the next step is to establish a nursing diagnosis, namely loss.

NURSING INTERVENTION

Goals for Patients:

a. Fostering a trusting relationship with nurses
b. Recognize the loss event experienced by the patient
c. Understanding the relationship between the loss experienced and his condition
d. Identify ways to deal with the grieving they experience
e. Utilize supporting factors.

Intervention for Patients:

a. Intervention a trusting relationship with the patient
b. Discuss the patient's current condition (state of mind, feelings, physical, social, and spiritual before/after experiencing the loss and the relationship between the current condition and the loss that occurred).
c. Discuss how to deal with grief experienced
   1) Verbal way (expressing feelings)
   2) Physical way (providing opportunities for physical activity)
   3) Social way (sharing through groups)
   4) Spiritual way (praying, surrendering)
d. Provide information about available community resources to share experiences with each other carefully.
e. Helping patients enter activities in the daily schedule.
f. Collaboration with the mental health team (Psychologist, Psychiatrist).

Goals for families:

a. Recognize the problem of loss and grieving.
b. Understand how to care for patients with prolonged grieving.
c. Practicing how to care for dysfunctional grieving patients.
d. Utilize the resources available in the community.

Intervention for families:

a. Discuss with the family about the problem of loss and grieving and its impact on the patient.
b. Discuss with the family ways to deal with grief experienced by the patient.
c. Training families to practice how to care for patients with dysfunctional grief.
d. Discuss with the family the sources of assistance that the family can use to deal with the loss experienced by the patient.

NURSING EVALUATION

The success of nursing actions can be seen from the patient's ability to

a. Able to build a trusting relationship with nurses
b. Able to recognize the event of loss experienced by the patient
c. Understand and accept the relationship between the loss experienced and his condition
d. Identify ways to deal with the grieving they experience
e. Utilize supporting factors.

SUMMARY

Loss is an experience that has been experienced by every individual during the life span since the individual has experienced it and tends to experience it again, although in a different form. Symptoms that occur in patients with loss include: adaptation to loss that does not work, depression, prolonged denial, slow emotional

reactions, unable to accept normal life patterns. self, fails to develop new relationships/interests, fails to rebuild life after loss.

REVIEW QUESTIONS

Analyze the process of loss and interventions that can be done for patients and their families!

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CHAPTER VI
NURSING CARE IN PATIENT WITH CHRONIC LOW SELF-ESTEEM

LEARNING OBJECTIVES

After studying this subject, students will be able to do the following:

1. Organizing the definition of chronic low self-esteem
2. Constructing the process of problem of chronic low self-esteem
3. Planning nursing care in patient with chronic low self-esteem

INTRODUCTION

Chronic low self-esteem is a feeling in a person that think that he is negative. Low self-esteem involves low self-evaluation negative and associated with feelings of weakness, helplessness, hopeless, scared, vulnerable, fragile, incomplete, worthless, and inadequate. Chronic low self-esteem is wrong one problem of nursing schizophrenia, because of low self-esteem is a negative symptom of schizophrenia. Self-esteem increases when cared for or loved and appreciated or proud. A person's self-esteem level is in the high range to low. Positive level of self-esteem is characterized by anxiety low, effective in groups and accepted by others. Individual who has high self-esteem to face the environment actively and capable adapt effectively to change and tend to feel secure whereas individuals who have low self-esteem look at the environment in a negative way and perceive it as a threat. Impaired self-esteem low will occur if you lose affection. the treatment of other people threatening and poor interpersonal relationships.

DEFINITION

Chronic low self-esteem is negative judgments or feelings about oneself or one's abilities that have lasted for a long time.

THE PROCESS OF CHRONIC LOW SELF-ESTEEM

The process of low self-esteem in patients includes stressors from predisposing and precipitation factors.

a. **Predisposing Factors**

Things that can affect the occurrence of low self-esteem, include:

Biological factors of low self-esteem are at risk if there are hereditary factors in family members who have mental disorders, history of illness or head trauma.

Psychological risk factors that can affect a person's low self-esteem are when a person has had an unpleasant past experience, such as: rejection, unrealistic parental expectations, repeated failures; lack of personal responsibility; dependency on others; patient's negative self-assessment of self-image, identity crisis, disturbed roles, unrealistic self-ideals; the influence of individual internal judgments.

Socio-cultural influences that are at risk for someone to experience low self-esteem are negative assessments from the environment towards patients that affect patient assessment, low socioeconomic status, history of environmental rejection at the stage of child development, and low education levels.

b. **Precipitation Factor**

Precipitating factors or triggers for the emergence of low self-esteem problems include:

1) Trauma: sexual or psychological abuse or witnessing a life-threatening event.
2) Role tension: frustration with expected roles or positions.
    a) Developmental role transition: normative changes related to growth.

b) Situation role transition: occurs by increasing or decreasing family members through birth or death.
c) Health-ill role transition: as a result of the shift from a state of health to a state of illness. This transition can be precipitated by the loss of a body part; changes in body size, shape, appearance or function; physical changes associated with normal growth and development; medical and nursing procedures.

c. Signs and Symptoms of Chronic Low Self-Esteem

Signs and symptoms of low self-esteem can be assessed from the patient's expressions that show negative judgments about themselves and are supported by data from interviews and observations.

1) Subjective data:
   Patient expresses about:
   a) Negative self or others
   b) Feelings of inadequacy
   c) Pessimistic outlook on life
   d) Denial of self-ability
   e) Judging yourself unable to deal with the situation
   f) Reject or rationalize positive feedback about self and excessive negative feedback about self
   g) Hesitation in trying new things/situations
2) Objective Data:
   a) Decreased productivity
   b) Expression of shame/guilt
   c) Not daring to look at the interlocutor
   d) More head bowed when interacting
   e) Speak slowly in a weak tone of voice

Other:
1) Frequent failures at work or other life events
2) Too submissive, dependence on others
3) Not as assertive as irritable/passive

4) Not strict
5) Too trying to convince

NURSING CARE IN PATIENT WITH CHRONIC LOW SELF-ESTEEM

This chronic low self-esteem nursing process is a management for patients with suicidal and psychotic cues.

a. Assessment

The assessment was carried out by means of interviews and observation in patients and families (caregiver).

Signs and symptoms of low self-esteem can be found through interviews with the following questions:

1) What is your view/assessment of yourself?
2) How does your assessment of yourself affect your relationships with other people?
3) What are your hopes?
4) What hopes have you achieved?
5) What hopes have you failed to achieve?
6) What efforts are you making to achieve unfulfilled expectations?

Signs and symptoms of low self-esteem that can be found through observation are as follows:

1) Decreased productivity
2) The patient does not dare to look at the interlocutor
3) Patients tend to lower their heads when interacting
4) Speak slowly in a weak tone of voice

b. Nursing Diagnosis

The nursing diagnosis is formulated based on the signs and symptoms of low self-esteem found. In patients with mental disorders, the nursing diagnoses that are enforced are chronic low self-esteem.

c. Nursing Actions on Chronic Low Self-Esteem

Nursing action slow self-esteem performed on patients and families (caregiver). Together with the family (carers), nurses identify problems experienced by patients and families (carers). After that, the nurse meets the patient to do an assessment and practice ways to overcome low self-esteem experienced by patients. After the nurse has finished training the patient, the nurse returns to meet the family (caregiver) and trains the family (caregiver) to care for the patient, as well as conveying the results of the actions that have been carried out on the patient and the tasks that the family needs to do, namely to guide the patient train activities that has been taught by nurses to overcome low self-esteem. Nursing actions for patients and families are carried out at every meeting, at least four meetings and continued until the patient is able to overcome low self-esteem and the family is able to treat low self-esteem.

d. Nursing Plan

Objective:

Patient is able to:

1) Build a trusting relationship
2) Identify capabilities and positive aspects possessed
3) Assess usable capabilities
4) Determine/select appropriate activities
5) Train activities that have been selected according to ability
6) Plan activities that have been trained.

Nursing actions:

1) Build a relationship of mutual trust, by:
    a) Say hello every time you interact with a patient.
    b) Introduce yourself to the patient: introduce the name and nickname that the nurse likes, and ask for the patient's preferred name and nickname.
    c) Ask the patient's current feelings and complaints.

d) Make a care contract: what the nurse will do with the patient, how long it will take, and where.
e) Explain that the Nurse will keep the information obtained confidential for the benefit of therapy.
f) Show empathy towards patients.
g) Meet the patient's basic needs whenever possible.

2) Identify the abilities and positive aspects that the patient still has.

   Nursing actions taken are:
   a) Identify the ability to carry out activities and positive aspects of the patient (make a list of activities)
   b) Give realistic compliments and avoid giving negative judgments every time you meet a patient.

3) Help the patient to assess the abilities that can be used.

   Nursing actions that can be taken are:
   a) Help the patient assess activities that can be done at this time (select from the list of activities): list activities that can be done at this time.
   b) Help the patient name it and provide reinforcement of the self-ability expressed by the patient.

4) Help the patient to choose/define activities based on a list of activities that can be done.

   Nursing actions that can be taken are:
   a) Discuss the activities to be selected for training during the meeting.
   b) Help the patient give reasons for the choices he made.

5) Practice activities that the patient has chosen according to ability.

   Nursing actions that can be taken are:
   a) Practice the selected activity (tools and how to do it).
   b) Help the patient enter on the activity schedule to exercise twice per day.

c) Provide concrete support and praise for any progress the patient shows.

6) Help the patient to plan activities according to his ability and develop an activity plan.

   Nursing actions that can be taken are:

   a) Give the patient the opportunity to try the activities that have been trained.
   b) Give praise for activities/activities that the patient can do every day.
   c) Increase activities according to tolerance levels and changes in each activity.
   d) Arrange a list of activities that have been trained with the patient and family.
   e) Give the patient the opportunity to express his feelings after the implementation of the activity.
   f) Make sure that the family supports every activity the patient does.

e. Evaluation:

For Patients

1) The patient shows signs and symptoms:
   a) Expresses acceptance of self and its limitations
   b) Maintain an upright posture, maintain eye contact
   c) Respect others
   d) Open communication
   e) Self-confident
   f) Receive compliments from others
   g) Respond as expected
   h) Feeling self-worth
2) Capable
   a) Reveals abilities and positive aspects possessed
   b) Assess and select capabilities that can be done
   c) Practicing workable skills

d) Make a schedule of daily activities
e) Carry out activities according to the daily schedule of activities
f) Feel the benefits of doing positive activities in overcoming low self-esteem

For Families (Caregivers)

Families can afford:

1) Know the low self-esteem experienced by patients (definition, signs and symptoms, the process of low self-esteem, and the consequences if low self-esteem is not treated)
2) Making decisions to treat low self-esteem
3) Treating low self-esteem
4) Creating a family atmosphere and environment that supports the patient to increase self-esteem
5) Monitor the improvement of the patient's ability to overcome low self-esteem
6) Follow up with health care providers, recognize signs of relapse, and make referrals.

SUMMARY

Low self-esteem is a condition in which the individual experiences a negative self-evaluation about his abilities. So it can be concluded that low self-esteem, namely someone who has trouble for assessing himself and the abilities he has, causes a loss of self-confidence that persists over time long. Low self-esteem is persistent feelings of worthlessness, worthlessness and low self-esteem as a result of a negative evaluation of oneself or one's abilities. There is a feeling of loss of self-confidence, a feeling of failure because you don't able to achieve the desire in accordance with the ideal self. Chronic low self-esteem, namely the client has a way of thinking negative. Incidence of illness and being treated will add to the perception negative towards him. This condition causes a

mal response adaptive. This condition can be found in clients with physical impairments chronic or in clients with mental disorders.

REVIEW QUESTIONS

Analyze the process of chronic low self-esteem disorder and interventions that can be done for patients and their families!

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CHAPTER VII

NURSING CARE IN PATIENT WITH SOCIAL ISOLATION

LEARNING OBJECTIVES

After studying this subject, students will be able to do the following:

1. Organizing the definition of social isolation
2. Constructing the process of problem of social isolation
3. Planning nursing care in patient with social isolation

INTRODUCTION

Social isolation is a state in which an individual experiences a decline or even completely unable to interact with other people around him. Patients may feel rejected, unaccepted, lonely, and unable to nurture meaningful relationships with other people. Social isolation is an experiment to avoid interaction and relationships with other people. Clients experiencing social isolation are characterized with flat affect, sad affect, not passionate/lethargic, no contact eyes, disinterest or refusal to interact with other people or environment, withdraws, feels insecure in public places, feels preoccupied with his own mind. Symptoms of social isolation rehabilitative is needed which aims to restore physical function, help adjust, increase tolerance, and improve ability of the patient to isolate. To minimize the impact of isolation social approach needed and provide management for address the symptoms of patients with social isolation. The role of the nurse in dealing with the problem of patients with social isolation, among others, implementing nursing care standards.

1. **Definition**

Social isolation is a condition in which an individual experiences a decline or is not even able to interact with other people around him at all. Patients may feel rejected, unaccepted, lonely, and unable to form meaningful relationships with others.

2. **The Process of Problem**

The process of social isolation in patients will be explained using Stuart's concept of adaptation stress which includes stressors from predisposing and precipitation factors,

a. **Predisposing factors**

Things that can affect the occurrence of social isolation, include:

1) Biological factors

Biological factors include the presence of hereditary factors having mental disorders, the risk of suicide, history of disease or head trauma, and history of drug use.

2) Psychological factors

In patients who experience social isolation, negative experiences of patients with self-image, unclear or exaggerated roles can be found, failure to achieve expectations or goals, identity crisis and lack of self-esteem and the environment that can cause disturbances in interacting with others. others, which ultimately becomes a matter of social isolation.

3) Socio-cultural factors

Social isolation patients generally come from low socioeconomic levels, a history of environmental rejection at the age of child development, low education levels and failures in social relationships (divorce, living alone).

b. **Precipitation factor**

Precipitation factors that can cause social isolation are history of infectious disease, chronic disease or structural brain disorder, family violence, failures in life, poverty, family

or community rules or demands that are often not in accordance with the patient's expectations, or conflicts between communities.

3. Signs and Symptoms of Social Isolation

Signs and symptoms of social isolation can be assessed from the patient's expressions that show negative judgments about social relationships and are supported by observational data.

a. Subjective data

Patient expresses about:

1) Lonely feeling
2) Feelings of insecurity
3) Feeling bored and time feels slow
4) Inability to concentrate
5) Feelings of being rejected

b. Objective Data

1) Much silence
2) Don't want to talk
3) Alone
4) Don't want to interact
5) Looks sad
6) Flat and shallow expression
7) Lack of eye contact

4. Social Isolation Nursing Process

a. Assessment

Assessment of social isolation patients can be carried out through interviews and observation of patients and families.

Signs and symptoms of social isolation can be found from the interview results, through the following forms of questions:

1) How do you feel when you interact with other people?
2) Is there a feeling of insecurity?
3) How do you feel about the people around you (family or neighbours)?

4) Do you have a family member or close friend? If you have, who are the family members and close friends?
5) Are there any family members or friends you are not close to? If you have, who are the family members and friends who are not close?
6) What keeps you from being close to this person?

Signs and symptoms of social isolation that can be found through observation are as follows:

1) The patient is silent and does not want to talk
2) The patient is alone and does not want to interact with those closest to him
3) Patient looks sad, expression flat and shallow
4) Lack of eye contact

b. Social Isolation Nursing Diagnosis

The nursing diagnosis is formulated based on the signs and symptoms of social isolation found. If the results of the assessment show signs and symptoms of social isolation, then the nursing diagnoses that are upheld are: social isolation

c. Nursing Plan in Patient with Social Isolation

Nursing actions for patients and families are carried out at every meeting, at least four meetings and continued until the patient and family are able to overcome social isolation.

1) Nursing Plan

Goals: Patients are able to:

a) Build a trusting relationship
b) Realizing the social isolation he experienced
c) Interact gradually with family members and the surrounding environment
d) Communicate when doing household activities and social activities

Nursing actions:

a) Build a trusting relationship
b) Helping patients become aware of social isolation behaviors
    - Ask the patient's opinion about the habit of interacting with other people
    - Ask what causes the patient not to want to interact with other people
    - Discuss the advantages of the patient having many friends and getting along well with them
    - Discuss the disadvantages if the patient just isolates himself and does not associate with other people
    - Explain the effect of social isolation on the patient's physical health
c) Train the patient to interact with other people gradually
    - Explain to the patient how to interact with others
    - Give an example of how to talk to other people
    - Give the patient the opportunity to practice how to interact with other people in the presence of the nurse
    - Help the patient interact with a friend/family member
    - If the patient is showing progress, increase the number of interactions with two, three, four people and so on
    - Give praise for each interaction progress that has been made by the patient
    - Train the patient to converse with family members when carrying out daily activities and household activities
    - Train patients to speak while carrying out social activities, for example: shopping at stalls, going to the market, going to the post office, going to the bank and so on.

- Ready to listen to the patient's expression of feelings after interacting with others. Perhaps the patient will reveal his success or failure. Give continuous encouragement so that the patient remains enthusiastic about increasing his interactions.

2) Nursing Plan for Families of Social Isolation Patients

The family (carers) are expected to be able to care for patients with social isolation at home and become an effective support system for patients.

Goals: Families are able to:

a) Recognize the problem of social isolation
b) Decided to treat patients with social isolation
c) Caring for patients with social isolation by teaching and accompanying patients to interact gradually, talking while carrying out household activities and social activities
d) Modifying a conducive environment so that patients are able to interact with the surrounding environment
e) Recognize the signs of recurrence and seek health services.

Nursing actions:

a) Discuss the perceived problems in caring for patients
b) Explain the meaning, signs and symptoms, causes of social isolation and consequences if social isolation is not overcome
c) Train families how to treat social isolation
d) Family training creates a family atmosphere and environment that supports the patient's increased social relationships
e) Discuss signs and symptoms of recurrence that require immediate referral to a health care facility
f) Encourage follow-up to health care facilities on a regular basis.

d. Evaluation of the Ability of Patients and Families in Caring for Social Isolation

1) Evaluate the patient's ability:
   - Describe interaction habits.
   - Explain the reasons for not getting along with other people.
   - Mention the advantages of associating with others.
   - Mentioned the disadvantages of not associating with other people.
   - Demonstrate how to get to know other people.
   - Mingle/interact with nurses, family, neighbors.
   - Communicating with family while doing daily activities
   - Communicate while doing social activities
   - Convey feelings after interacting with others.
   - Have a schedule of conversations with other people.
   - Experience the benefits of interacting exercises in overcoming social isolation

b) Evaluation of family capabilities(caretaker):
   - Get to know the social isolation experienced by patients
   - Help patients interact with others
   - Accompanying patients when carrying out household activities and social activities while communicating
   - Involve the patient in carrying out daily activities at home and outreach activities in the environment
   - Creating a family atmosphere and environment that supports the patient to increase social interaction
   - Monitor the improvement of the patient's ability to overcome social isolation
   - Follow up with health care facilities, recognize signs of relapse and make referrals

SUMMARY

Social isolation is a condition of loneliness experienced by individual and perceived as caused by others and as a condition negative and threatening. A person's social isolation is the client's inability to express feelings client that can cause the client to express the client's feelings violently. Social isolation is a condition in which a person experiences decreased interaction with other people and the environment surroundings, because they have experienced experiences that are not fun, rejected, not accepted, and so lonely people with social isolation prefer silence, self-isolation and avoid other people. Signs and symptoms of social isolation include: lack of spontaneous, apathetic (indifferent to the environment), less radiant facial expressions (sad expression), blunted affect, not caring and paying attention personal hygiene, absent or lacking in verbal communication, refusing to relate to others, self-isolating (alone), less aware of the surrounding environment, intake disturbed eating and drinking, decreased activity and low self-esteem.

REVIEW QUESTIONS

Analyze the process of social isolation and interventions that can be done for patients and their families!

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CHAPTER VIII

NURSING CARE IN PATIEN WITH SENSORY PERCEPTION DISODER

LEARNING OBJECTIVES

After studying this subject, students will be able to do the following:

1. Organizing the definition of sensory perception disorder
2. Constructing the process of problem of sensory perception disorder
3. Planning nursing care in patient with sensory perception disorder

INTRODUCTION

Hallucinations are a nuisance perception in which the patient perceives something that is not actually happening. The types of hallucinations are auditory, visual, olfactory, tasting and tactile. Auditory hallucinations are the most common type of hallucinations. Predisposing factors include biology (history of family members who have a mental disorder, history of illness or head trauma, and history of use of narcotics, psychotropics and other addictive substances (drugs). Factor psychological: have a history of repeated failures, victims, perpetrators and witnesses from violent behavior, lack of affection from the people around or over protective. Socio-cultural and environmental factors, including most of the hallucination patients come from families with low socio-economic status, there is a history of rejection from the environment at the age of child development, the level of education is low and experiences failure in social relations (divorce, living alone), as well as not working.

1. Definition

Hallucinations are perceptions or responses from the five senses without any external stimulus (Stuart, 2016). Hallucinations are perceptual disorders in which the patient perceives something that is not actually happening. Based on the five senses, hallucinations are divided into five types, namely auditory hallucinations, visual hallucinations, olfactory hallucinations, taste hallucinations and tactile hallucinations. The process of hallucinations in patients will be explained using Stuart's adaptation stress concept which includes stressors from predisposing and precipitation factors.

a. Predisposing Factors

Things that can affect the occurrence of hallucinations are:

1) Biological Factors:
   Biological factors include the presence of hereditary factors having mental disorders, the risk of suicide, history of disease or head trauma, and history of drug use.
2) *Psychological Factors*
   In patients who experience hallucinations, there may be repeated failures, victims of violence, lack of affection, or overprotection.
3) Socioculture *and environment*
   Hallucinatory patients can find a history of environmental rejection at the age of child development, low socioeconomic status, low educational level and failure in social relationships (divorce, living alone), and not working.

b. Precipitation Factor

Precipitation stressors in hallucinatory patients are found to have brain structural abnormalities, a history of infectious diseases, chronic illnesses, family violence, or failures in life, poverty, rules or demands in the family or society that are often inconsistent with patients and conflicts between communities.

2. Signs and Symptoms

Signs and symptoms of hallucinations are assessed from the results of observations of patients and the patient's expressions. The signs and symptoms of hallucinations are as follows:

a. Subjective Data:

Patient says:

1) Hearing voices or noise.
2) Hear a voice that invites conversation.
3) Hearing a voice ordering something dangerous.
4) Seeing shadows, rays, geometric shapes, cartoon shapes, seeing ghosts or monsters
5) Smelling smells like blood, urine, faeces, sometimes that smell is pleasant.
6) Tastes like blood, urine or feces
7) Feeling scared or happy with the hallucinations

b. Objective Data:

1) Talk or laugh to yourself
2) Angry for no reason
3) Pointing the ear in a certain direction
4) Cover your ears
5) Pointing in a certain direction
6) Fear of something that is not clear.
7) Smelling something is like smelling certain odors.
8) Cover nose.
9) Frequent spitting
10) Vomit
11) Scratching the surface of the skin

3. Hallucination Nursing Process

a. Hallucination Study

The assessment was carried out by means of interviews and observation in patients and families (carers).

Signs and symptoms of hallucinations can be found by

interview, through the following questions:

1) Did you hear voices?
2) Is seeing scary shadows?
3) Is smelling a certain odor repulsive?
4) Do you feel something creeping in your body?
5) Do you feel something disgusting and unpleasant?
6) How often do you hear voices or see these shadows?
7) When do you hear voices or see shadows?
8) In what situations did you hear voices or see shadows?
9) How did you feel when you heard the sound or saw the shadow?
10) What had he done, when he heard the voice and saw the shadow?

Signs and symptoms of hallucinations that can be found through observation are as follows:

1) The patient appears to be talking or laughing to himself
2) Angry for no reason
3) Tilt or point the ear in a certain direction or cover the ear.
4) Pointing in a certain direction
5) Fear of something that is not clear
6) Sniffing is like smelling certain odors.
7) Cover nose.
8) Frequent spitting
9) Vomit
10) Scratching the skin surface

b. Nursing Diagnosis Hallucinations

A nursing diagnosis is formulated based on the signs and symptoms of hallucinations found. The formulation of a nursing diagnosis is sensory perceptual disorders: hallucinations

c. Hallucination Nursing Actions

Nursing actions in hallucinatory patients are carried out for patients and families (caretakers). Before providing nursing

actions, the nurse conducts an assessment of the patient and family (caretaker) and then trains how to deal with the hallucinations experienced by the patient.

At the first meeting with the patient and family, the nurse also needs to discuss the psychopharmacological therapy that the patient has received. Nurses discuss the importance of medication adherence to overcome hallucinations, train patients to deal with hallucinations and train families (caretakers) to care for patients and the tasks that families need to do, namely to remind patients to practice problem-solving skills that have been taught by nurses.

1) Nursing Plan for Hallucination Patients

Objective: Patient is able to:

a) Build a trusting relationship
b) Recognize hallucinations
c) Control hallucinations

Nursing actions

a) Build a trusting relationship.
b) Helping patients realize the hallucinations they are experiencing
    - Ask the patient about the hallucinations he is experiencing: without supporting or denying the hallucinations.
    - Identify hallucination content, frequency of appearance of hallucinations, time of occurrence of hallucinations, situation of appearance of hallucinations, feelings, responses and efforts made by the patient to eliminate or control hallucinations.
c) Train the patient to control hallucinations

In detail, the stages of training the patient to control hallucinations can be done as follows:

- Explain how to control hallucinations by fighting hallucinations (rebuking), diverting (conversing with

other people and doing scheduled activities at home, such as making the bed, sweeping the floor, or washing clothes, etc.), obeying taking medication.

- Give examples of how to fight hallucinations by scolding, how to divert hallucinations by asking other people for help to converse during hallucinations and making a schedule of daily activities at home.
- Discuss the 6 (six) right to take medicine,
- Give the patient the opportunity to practice how to fight hallucinations by rebuking, diverting hallucinations by conversing with other people and arranging a schedule of daily activities at home.

d) Give praise for each patient progress.

e) Listening to the expression of the patient's feelings after carrying out nursing actions to control hallucinations. Perhaps the patient will reveal his success or failure. Give continuous encouragement so that the patient remains enthusiastic about improving his practice.

2) Nursing Plan for Families of Hallucination Patients

Families (caregivers) are expected to be able to treat hallucinatory patients at home and become an effective support system for patients.

Objective: Families can afford:

a) Know about hallucinations
b) Make a decision to treat hallucinations
c) Caring for family members who experience hallucinations
d) Modify the environment that supports the patient to overcome hallucinations
e) Utilize health service facilities

Nursing actions:

a) Discuss the perceived problems in caring for patients

b) Explaining hallucinations: understanding, signs and symptoms, causes of hallucinations, and consequences if hallucinations are not treated.
c) Helping families make decisions about caring for patients
d) Train the family how to treat hallucinations
e) Guiding the family to treat hallucinations
f) Training the family creates a family atmosphere and environment that supports the patient in dealing with hallucinations
g) Discuss signs and symptoms of recurrence that require immediate referral to a health care facility
h) Encourage follow-up to health care facilities on a regular basis.

Nursing actions for the family (caretakers) are carried out simultaneously with meetings with patients. When the nurse coaches the patient on problem solving, the family is with the patient and involved in activities.

Discuss the perceived problems in treating hallucinatory patients, explain the meaning, signs and symptoms, causes of hallucinations, and the consequences of hallucinations (use leaflets or booklets on how to caring for families with hallucinations), explain how to treat hallucinations, train families how to care for them, provide guidance assistance to patients, suggest helping patients according to schedule and give praise.

d. Evaluation of the Ability of Patients and Families in Treating Hallucinations

Evaluation of the success of nursing actions that have been carried out for hallucinatory patients is as follows:

1) Patient is able to:
    - Reveals the contents of the hallucinations he experienced
    - Describe the timing and frequency of the hallucinations experienced.
    - Describe the situation that triggers the hallucination
    - Describe how you feel when you have hallucinations
    - Implement 4 ways to control hallucinations:
        - Rebuke hallucinations
        - Adhere to the treatment program
        - Inviting other people to converse with when hallucinations arise
        - Arrange a schedule of daily activities to reduce free time and carry out the schedule of these activities independently
    - Assess the benefits of how to control hallucinations in controlling hallucinations
2) Families can afford:
    - Describe the hallucinations experienced by the patient
    - Explain how to treat hallucinatory patients
    - Demonstrate how to treat hallucinatory patients
    - Describe health facilities that can be used to treat hallucinations.

SUMMARY

Hallucinations are a symptom in individuals with mental disorders experiencing impaired sensory perception changes marked by the client sensations such as sound, sight, taste, touch, or subsistence without a real stimulus. Hallucination already melted down and the patient felt very scared, panicked and could not differentiate between fantasy and reality. The impact that can be caused by patients who experience Hallucinations are losing self-control. The patient will experience panic and his behavior is

controlled by hallucinations. In this situation the patient can do suicide, killing others (homicide), even damage environment. With this situation the patient will feel ostracized by environment that causes social isolation, the patient will also feel humiliated a result of actions that have been taken that lead to low self-esteem, with the existence of a trauma situation that the patient experienced will be able to cause post-distress trauma in the environment, the patient can feel excessive fear when in public. Lack of communication and family warmth also causes clients unable to be independent since childhood and easily frustrated, lost confidence and more susceptible to stress. The patient's response to hallucinations is talking, smiles, laughs to himself, muddled speech, avoids others, say listening to sounds, unable to distinguish the real thing and thing which is not real.

REVIEW QUESTIONS

Analyze the process of sensory perception disorder and interventions that can be done for patients and their families!

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CHAPTER IX

NURSING CARE IN PATIENT WITH VIOLENT BEHAVIOR

LEARNING OBJECTIVES

After studying this subject, students will be able to do the following:

1. Organizing the definition of violent behavior
2. Constructing the process of problem of violent behavior
3. Planning nursing care in patient with violent behavior

INTRODUCTION

Patients with mental disorders are often taken to psychiatric hospital in emergency rooms is bound hand and foot. As a nurse, of course you will think surely at home or in the environment where the patient is carrying out violent behavior has disturbed him environment and endanger yourself and others. Violent behavior is a human behavioral response to damage as a form physical aggression committed by someone against other people and or something. Violent behavior is the result of extreme anger or fear in response to feelings threatened, whether in the form of threats of physical attack or self-concept. This feeling of being threatened can comes from the outside environment (physical assault, loss of significant others and criticism from others) and internal environment (feelings of failure at work, feelings of not affection and fear of physical illness).

DEFINITION

Stuart and Laraia (2005), state that violent behavior is the result of extreme anger (anger) or fear (panic) in response to feelings of threat, either in the form of threats of physical attack or self-concept. These feelings of threat can come from external stressors (physical assault, loss of a significant other and criticism

from others) and internal (feelings of failure at work, feeling of not getting affection and fear of physical illness).

Violent behavior is a form of behavior that aims to injure someone physically or psychologically (Keliat, et al., 2011). The risk of violent behavior is behavior that shows the individual can threaten physically, emotionally and or sexually to other people (Herdman, 2012). So it can be said that violent behavior is:

a) Emotional response that arises as a reaction to increased anxiety and is felt as a threat (ridicule/humiliated).
b) Expression of feelings towards unpleasant circumstances (disappointed, desires not achieved, dissatisfaction).
c) Violent behavior can be done verbally, directed at oneself, others, and the environment.

THE PROCESS OF VIOLENT BEHAVIOR

The process of violent behavior in patients will be explained using Stuart's adaptation stress concept which includes:

a. Predisposing Factors

Things that can influence the occurrence of violent behavior, include:

1) Biological Factors

Biological factors include the presence of hereditary factors having mental disorders, history of disease or head trauma, and history of drug use.

2) Psychological Factors

The experience of anger is the result of a psychological response to external, internal or environmental stimuli. Violent behavior occurs as a result of accumulated frustration. Frustration occurs when an individual's desire to achieve something fails or is hampered, such as physical health or social relationships that are disrupted. One of the human needs is to "behave", if this need cannot be fulfilled through constructive behavior, then what will emerge is

that the individual behaves destructively.

3) Sociocultural Factors

Disturbed social functions and relationships accompanied by a social environment that threatens individual needs, which affects individual attitudes in expressing anger. Cultural norms can influence individuals to respond assertively or aggressively. Violent behavior can be learned directly through the process of socialization (social learning theory), which is a process of imitating the environment that uses violent behavior as a way of solving problems.

b. Precipitation Factor

Precipitation factors that can cause violent behavior in each individual are unique, different from one person to another. These stressors can be causes that are external or internal factors from the individual. Internal factors include unfulfilled desires, feelings of loss and failure in life (job, education, and loss of loved ones), worries about physical illness.External factors include changing social activities or events such as physical attacks or acts of violence, derogatory criticism, an environment that is too noisy, or a breakdown in social/work/school relations.

c. Signs and Symptoms

Signs and symptoms of violent behavior can be assessed from the patient's expressions and supported by observational data. Subjective data: the expression is a threat, harsh words and expressions of wanting to hit/injure. Objective data: face flushed and tense, sharp look, clench jaw firmly, clench fists, rough talk, high voice, screaming or shouting, back and forth, throwing or hitting objects/other people.

NURSING PROCESS VIOLENT BEHAVIOR

a. Assessment

The assessment was carried out by interviewing and observing patients and their families (caregiver). Signs and symptoms of violent behavior can be found by interviewing through the following questions:

1) What causes feelings of anger?
2) What did you feel when the incident/causes of anger occurred?
3) What do you do when you're angry?
4) Does the method used cause anger disappear?
5) What are the consequences of the way you get angry?

Signs and symptoms of violent behavior can be found through the following observations:

1) Face flushed and tense
2) Sharp look
3) Clench jaw firmly
4) Clench fists
5) Rough talk
6) Back and forth
7) High pitched voice, screaming or shouting
8) Throwing or hitting objects/other people

b. Nursing Diagnosis

The nursing diagnosis is formulated based on the signs and symptoms obtained in the assessment. In the problem of violent behavior there are two possible nursing diagnoses, namely violent behavior and risk violent behavior.

c. Nursing Plan

In the nursing diagnosis of violent behavior, the nursing actions taken primarily aim to prevent the patient from injuring himself, others or the environment. Nursing actions at the risk of violent behavior, carried out on patients and families

(caregiver). Nurses identify problems experienced by patients and families (carers). After that, the nurse conducts an assessment of the patient and trains how to deal with the problems experienced by the patient.

If the patient receives psychopharmacological therapy, the nurse also explains the importance of medication adherence. Nurses train patients accompanied by their families, so that families also learn how to train/care for patients. Families have a task that needs to be done, namely to remind patients to practice problem-solving skills that have been taught by nurses and apply them when problems arise. Nursing actions for patients and families are carried out at every meeting, at least four meetings and continued until the patient and family are able to overcome the problem of violent behavior.

a) Nursing Plan for Patients

   Objective:

   Patient is able to:

   a) Build a trusting relationship
   b) Explain the cause of anger
   c) Describe feelings when angry/violent behavior occurs
   d) Describe the behavior performed when angry
   e) Mention ways to control anger/violent behavior
   f) Doing physical activity in channeling anger
   g) Take medication regularly
      (1) Speak in a kind way
      (2) Do religious activities to control anger

   Nursing actions:

   a) Build a trusting relationship

      The actions taken in order to build a trusting relationship are:

      (1) Introduce yourself: name, the nurse's preferred nickname, and ask the patient's preferred name and nickname.

(2) Say hello every time you interact with a patient
(3) Ask the patient's current feelings and complaints
(4) Making a care contract: what the nurse will do with the patient, how long it will take and where to meet.
(5) Show empathy

b) Discuss with the patient the causes of anger that lead to current or past violent behavior.
c) Discuss the signs in the patient if violent behavior occurs
(1) Discuss signs and symptoms of physically violent behavior
(2) Discuss signs and symptoms of psychologically violent behavior
(3) Discuss signs and symptoms of socially violent behavior
(4) Discuss the signs and symptoms of spiritually violent behavior
(5) Discuss signs and symptoms of intellectually violent behavior

d) Discuss with the patient violent behavior that is usually done when angry by:
(1) verbal
(2) towards others
(3) against yourself
(4) to the environment

e) Discuss with the patient the consequences of his behavior
f) Train patients how to control violent behavior by:
(1) Physical: take a deep breath, hit the bed and cancel.
(2) Obediently take medication
(3) Social/verbal (good speech): asking, refusing and expressing feelings
(4) Spiritual: pray/pray according to the patient's beliefs

Nursing actions for families

Objective:

Families are able to:

a) Recognize the problem of risk of violent behavior
b) Decided to treat patients at risk of violent behavior
c) Caring for patients at risk of violent behavior by teaching and accompanying patients to control their emotions by doing physical activities, speaking well, taking medication regularly and carrying out religious activities
d) Modifying a conducive environment so that patients are able to control violent behavior and reduce stressors that lead to violent behavior
e) Recognize signs of relapse and use health services to treat problems.

Nursing actions:

a) Discuss the perceived problems in caring for patients.
b) Explain the meaning, signs and symptoms, and causes of violent behavior.
c) Train families how to care for the risk of violent behavior.
d) Guiding families to treat the risk of violent behavior.
e) Training the family creates a family atmosphere and environment that supports the patient to control his emotions.
f) Discuss signs and symptoms of recurrence that require immediate referral to a health care facility
g) Encourage follow-up to health care facilities on a regular basis.

d. Evaluation

1) Evaluation of the patient's ability to risk violent behavior, the patient can:

a) Mention the causes, signs and symptoms of violent behavior, the usual violent behavior, and the consequences of the violent behavior committed.

b) Controlling violent behavior:
   (1) physically: take a deep breath and hit the pillow/mattress
   (2) socially/verbally: requesting, refusing, and expressing feelings in a kind way
   (3) spiritually
   (4) using psychopharmacological therapy
c) Conduct regular violent behavior control exercises according to a schedule
d) Identify the benefits of the exercises carried out in preventing violent behavior

2) Evaluation of the ability of families (carers) to risk violent behavior, families can:
   a) Recognize the perceived problems in treating patients (definition, signs and symptoms, and causes of violent behavior)
   b) Preventing violent behavior
   c) Demonstrate a supportive and respectful attitude towards patients
   d) Motivate the patient in controlling feelings of anger
   e) Creating a family atmosphere and environment that supports the patient in controlling feelings of anger
   f) Evaluate the benefits of nursing care in preventing violent behavior of patients
   g) Follow up with health care facilities and recognize signs of relapse.

SUMMARY

The process of occurrence of violent behavior includes predisposing factors: biological factors due to hereditary factors, namely the presence of frequent family members showing or carrying out violent behavior, presence of family members that have

a mental disorder, have a history of illness or head trauma, and history of drug use (narcotics, psychotropics and other additives). Psychological factors, namely the experience of anger is a psychological response to external stimuli, internal and environmental. Violent behavior occurs as a result of accumulated frustration. Frustration occurs when the individual's desire to achieve something fails or gets stuck. Sociocultural factors namely social environmental theory states that the environment social influence greatly affects the attitude of individuals in expressing angry. Cultural norms can support individuals to respond assertively or aggressive. Violent behavior can be learned directly through the process socialization (social learning theory).

Precipitation factor: factors from within the individual include losing relationships or relationships with people loved or significant (breakup, divorce, death), loss of love, worry about physical illness, etc. While the external factors include the individual physical attacks, too noisy environment, criticism that leads to humiliation, acts of violence.

REVIEW QUESTIONS

1) Explain the predisposing and precipitation factors of violent behavior?
3) Describe the signs and symptoms of violent behavior?
4) Explain how to deal with violent behavior physically and spiritually as well as drugs?

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CHAPTER X

NURSING CARE IN PATIENT WITH DELUSION

LEARNING OBJECTIVES

After studying this subject, students will be able to do the following:

1. Organizing the definition of delusion
2. Constructing the process of problem of delusion
3. Planning nursing care in patient with delusion

INTRODUCTION

Disorders of delusional thought processes is a belief that is very impossible and firmly held despite not having clear evidence, and even though everyone don't believe in faith. Delusion itself is divided into five kinds, namely delusions of greatness, delusions of suspicion, religious delusions, delusions somatic, and nihilistic delusions. This delusional thought process disorder is a symptom positive of schizophrenia and usually people who have these symptoms will do things according to the type of delusion, namely by possessing high suspicion of self and others, feeling have great power, feel they have extraordinary power far above humans in general, feel he has a disease that very severe or can be transmitted to other people, as well as consider himself already dead. Disruption of delusional thought processing is characterized by the presence of at least one month experience delusions and the absence of other symptoms that are usually included delusion itself. Delusions are also categorized into two, namely non-delusions bizarre and bizarre delusions. non-bizarre delusions are beliefs that can be imagined correctly or real, for example a life partner who having an affair and feeling spied on by a government agency. Whereas Bizarre delusions have no possible basis in life real, like replacing all of a person's organs without doing

operation.

1. DEFINITION

Delusion is a false belief that is maintained strongly/ continuously but is not in accordance with reality.

Signs and symptoms of delusions are:

a. Delusion of greatness

Believing that he has special greatness or power, uttered many times but not according to reality.

Example:

"I am an official at the Ministry of Health, you know.." or "I have a gold mine"

b. b. I'm suspicious

Believing that someone or a group is trying to harm/injure themselves, is said repeatedly but does not correspond to reality.

Example: "I know...all my siblings want to destroy life me because they are jealous of my success."

c. Religious delusions

Having excessive belief in a religion, said repeatedly but not in accordance with reality

Example: "If I want to go to heaven, I have to wear white clothes every day"

d. Somatic delusions

Believing that the body or parts of the body are disturbed/affected by disease, said repeatedly but not in accordance with reality.

2. The Process of Occurrence of Delusions

The process of delusions in patients will be explained using Stuart's concept of adaptation stress, including:

a. Predisposing Factors

1) Biological

Biological factors for the occurrence of delusions include hereditary factors, risk of suicide, history of illness

or head trauma, or history of drug use.

2) Psychological

Repeated failures, victims of violence, lack of affection, or overprotection.

3) Socioculture and environment

Low socio-economic, history of environmental rejection at the age of child development, low education level and failure in social relations (divorce, living alone), and not working.

b. Precipitation Factor

There is a history of infectious diseases, chronic diseases or structural brain disorders, family violence, or failures in life, poverty, family or community rules or demands that are often inconsistent with patients and conflicts between communities.

3. Signs and Symptoms

Signs and symptoms of delusions are assessed from the results of observations of patients and patient expressions. The signs and symptoms of delusional patients are as follows:

a. Subjective Data

Patient says:

1) Has extraordinary strength.
2) Someone is stalking or threatening him.
3) Television or radio broadcasts things related to him
4) There was a part of his body that was disturbed

b. Objective Data

1) Using strange clothing or attributes
2) Terrified expression
3) Anxious signs
4) Limit interactions with other people

4. Delusional Nursing Process

a. Delusion Study

Here are some sample questions that you can use as a guide for assessing delusional patients:

1. Does the patient have thoughts/thought content that is repeatedly expressed and persists?
2. Is the patient afraid of certain objects or situations, or is the patient unreasonably anxious about their body or health?
3. Has the patient ever felt that the objects around him are strange and unreal?
4. Does the patient ever feel that he is outside his body?
5. Does the patient ever feel watched or talked about by others?
6. Does the patient think that his thoughts or actions are controlled by other people or outside forces?
7. Does the patient state that he has physical or other strengths or believes that others can read his mind?

b. Nursing Diagnosis

The nursing diagnosis is formulated based on the signs and symptoms of the delusions found. If the results of the assessment show signs and symptoms of delusions, then the nursing diagnoses that are upheld are: delusions

c. Delusional Nursing Actions

1) Nursing actions for patients

Objective

a) Patients can be oriented to reality gradually
b) Patients are able to interact with other people and the environment
c) Patients use drugs with the 6 principles of right

Action

a) Build a trusting relationship

The actions that you must take in order to build a trusting relationship are:

- Say hello therapeutic
- Shake hands

- Describe the purpose of the interaction
- Make a topic contract, time and place every time you meet a patient.
- Do not support or refute the patient's delusions

b) Make sure the patient is safe
c) Observing the effect of delusions on daily activities
d) If the patient continues to talk about his delusion, listen without providing support or denying it until the patient stops talking about it
e) Identify with the patient unmet needs
f) Identify with the patient resources that can be used to meet unmet needs
g) Assist in meeting patient needs
h) Give praise when the patient's appearance and orientation match reality and the patient shows positive abilities.
i) Discuss with the patient the realistic capabilities of the past and present
j) Encourage patients to carry out activities according to their abilities.
k) Discuss psychological/emotional needs that are not met, causing anxiety, fear and anger.
l) Help the patient to increase activities that can meet the patient's physical and emotional needs
m) Speak in the context of reality
n) Discuss the benefits of the drug.

2) Nursing action for the family

Objective:

a) The family is able to identify the patient's delusions
b) The family is able to facilitate the patient to meet the needs fulfilled by his delusions.
c) The family is able to maintain the patient's treatment program optimally

Action:

a) Discuss with the family about the delusions experienced by the patient
b) Discuss with family about:
    - How to treat delusional patients at home
    - The right environment for the patient.
    - Follow up and regularity of treatment
c) Discuss with the family about the patient's medication
d) Discuss with the family about the patient's condition that requires immediate consultation

d. Evaluation of the Ability of Patients and Families in Treating Delusions

1) Patient is able to:
    a) express their beliefs according to reality
    b) communicate reality
    c) use drugs correctly and obediently
2) Families can afford:
    a) Help the patient to express his beliefs according to reality
    b) Helping patients carry out activities according to the abilities and needs of patients
    c) help patients use drugs correctly and adherence

SUMMARY

A delusion is a false belief that is strongly defended or continuous, but not in accordance with reality. Delusion is including thought disturbances. The patient believes that he is like what's on his mind. Delusions are frequently encountered in distractions severe psyche and some specific forms of delusions are often found in schizophrenics delusion is a false belief and fixed, not based on reality. Delusions or delusions are beliefs that do not correspond to reality. Delusions occur because of circumstances that arise as a result of the projection of where one casts flaws and unease into the

outside world. That individual usually sensitive and irritable cold demeanor and tends to withdraw. Circumstances This is often caused by feeling uncomfortable in the environment, feeling hate, stiff, love is self-exaggerated, arrogant and stubborn. With frequent use

projection mechanism and the tendency to daydream and yearn for something excessively, then this situation can develop into delusions. Gradually the individual cannot escape from his delusion and then leave the world of reality. Meanwhile, self-love, arrogance and stubbornness, insecurity, makes a person fantasize that he often becomes ruler and this can develop into a big delusion.

REVIEW QUESTIONS

1) Explain the predisposing and precipitation factors of delusions?
2) Describe the signs and symptoms of delusions?

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CHAPTER XI
NURSING CARE IN PATIENT WITH SELF-CARE DEFICIT

LEARNING OBJECTIVES

After studying this subject, students will be able to do the following:

1. Organizing the definition of self-care deficit
2. Constructing the process of self-care deficit
3. Planning nursing care in patient with self-care deficit

INTRODUCTION

Mental disorders are divided into two types, namely mild mental disorders and severe mental disorder. Schizophrenia is a serious mental disorder which will burden society throughout the sufferer's life, marked with disorganized thoughts, feelings and behaviors and self-care deficits. Self-care deficit is a condition in someone who experience a weakness in the ability to complete maintenance activities independently such as bathing, decorating, eating and defecating. Self-care deficit is the state of a person experiencing abnormalities in the ability to perform or complete activities of daily living independently. There isn't any desire to bathe regularly, not combing hair, dirty clothes, body odor, bad breath and untidy appearance.

DEFINITION

Self-care is one of the basic human capabilities in meeting their needs in order to maintain life, health and well-being in accordance with their health conditions. Self-care deficit is a disorder of the ability to carry out self-care activities (personal hygiene, decorating, eating, toileting) (Herdman, 2012).

1. Problem Occurrence Process

Things that can affect the occurrence of self-care deficit, include

a. Predisposing factors
   1) Biological: physical and mental illness that causes the patient to be unable to perform self-care and hereditary factors.
   2) Psychological: developmental factors in which the family overprotects and spoils the patient so that initiative development is disrupted. Reality ability drops. Mental patients with reduced reality abilities lead to indifference to themselves and their environment, including self-care.
   3) Social: lack of support and environmental situations affect the ability to self-care.

b. Precipitation factor

   Precipitation factors that can cause self-care deficits are decreased motivation, cognitive or perceptual impairment, anxiety, fatigue, weakness experienced by individuals, causing individuals to be less able to perform self-care.

2. Signs and Symptoms of Self-care Deficit

Signs and symptoms of self-care deficit can be assessed from the patient's statements about personal hygiene, grooming and dressing, eating and drinking, defecation and urination and are supported by observational data.

a. Subjective data

   Patient says about:
   1) Lazy shower
   2) Unwilling to comb hair
   3) Don't want to brush my teeth
   4) Don't want to cut nails
   5) Do not want to decorate/dress up
   6) Unable/unwilling to use toiletries/personal hygiene

7) Do not use eating and drinking utensils when eating and drinking
8) Elimination carelessly
9) Do not clean yourself and place of defecation and urination after defecation and urination
10) Don’t know how to properly care for yourself

b. Objective data

1) Body odor, dirty, climbing, dirty hair and teeth, long and dirty nails, not using toiletries, not bathing properly
2) Tangled hair, messy, untidy mustache and beard, untidy clothes, unable to dress up.
3) Eat and drink carelessly, scatter, do not use cutlery; unable to prepare food, transfer food to cutlery, handle cutlery, finish eating
4) Defecating and urinating not in the right place, not cleaning oneself after defecating and urinating, not being able to keep the toilet clean

3. Self-care Deficit Nursing Process

a. Self-care Deficit Assessment

The assessment was carried out by conducting interviews and observations of patients and families (caregiver).

Signs and symptoms of self-care deficit can be obtained from interview results, through the following questions:

1) How is the patient’s personal hygiene?
2) Is the patient lazy to take a bath, wash hair, brush teeth, cut nails?
3) How does the patient look?
4) Does the patient comb his hair, dress up, shave (for boys)?
5) Is the patient’s clothing neat and appropriate?
6) Does the patient use personal hygiene?
7) How is the patient eating and drinking?

8) Does the patient use eating and drinking utensils when eating and drinking?
9) How is the patient's urinate and defecate?
10) Does the patient clean himself and the place for defecation and urination after defecation and urination?
11) Does the patient know the correct way of self-care?

Signs and symptoms of self-care deficit that can be found through observation are as follows:

1) Impaired personal hygiene is characterized by dirty hair, dirty teeth, sticky and smelly skin, long and dirty nails.
2) The inability to dress/dress up is characterized by disheveled hair, dirty and untidy clothes, inappropriate clothing, unshaven male patients, and undressed female patients.
3) Inability to eat and drink independently, characterized by the inability to take food and drink independently, eat scattered, and eat inappropriately.
4) Inability to defecate and urinate independently, marked by defecation and urination not in the right place, not cleaning oneself properly after defecation and urination.

b. Nursing Diagnosis

A nursing diagnosis is formulated based on the signs and symptoms of self-care deficit found. If the results of the assessment show signs and symptoms of self-care deficit, then the nursing diagnoses that are enforced are self-care deficit: personal hygiene, grooming, eating and toileting.

c. Nursing Plan

Nursing actions for self-care deficits are carried out for patients and families (caretakers). Nurses identify problems experienced by patients and families (carers). After that, the nurse conducts an assessment and trains how to overcome the self-care deficit experienced by the patient. When taking

care of patients, the family also accompanies and practices how to care for them. The nurse motivates the task that the family needs to do, namely guiding the patient to do how to overcome the self-care deficit that has been taught by the nurse and giving praise if the patient has done it.

1) Nursing Plan

Goals: The patient is able to:

a) Build a trusting relationship
b) Perform self-cleaning independently
c) Make up/dress up properly
d) Do eat and drink in a good way
e) Perform elimination independently

Nursing Plan for Patients with Self-care Deficits

1) Fostering a trusting relationship by:
2) Train patients in ways of personal hygiene care

   To train patients in maintaining personal hygiene, nurses can carry out stages of action which include:

   - Explain the importance of maintaining personal hygiene.
   - Explain the tools for maintaining personal hygiene
   - Explain how to do personal hygiene.
   - Train patients to practice personal hygiene.

3) Train patients to dress up/make up
   - For male patients the exercises include:
     - get dressed
     - Comb the hair
     - Shave
   - For female patients, the exercises include:
     - get dressed
     - Comb the hair
     - ornate

4) Train the patient to eat and drink independently
   To train patients to eat and drink, nurses can carry out the following steps:
   - Explaining needs (food needs per day for adults 2000-2200 calories (for women) and for men between 2400-2800 calories per day eating and drinking 8 glasses (2500 ml per day) and how to eat and drink
   - Explain how to eat and drink in an orderly manner.
   - Explain how to tidy up eating and drinking utensils after eating and drinking
   - Practice eating according to the stages of good eating

5) Teach patients to defecate and urinate independently
   Nurses can train patients to defecate and urinate independently according to the following stages:
   - Explain the appropriate place for urinate and defecate
   - Explain how to clean yourself after defecating and urinating
   - Explain how to clean the place for defecation and urination

2) Nursing Plan for Families of Self-care Deficit Patients

The family (caregiver) are expected to be able to care for patients with self-care deficits at home and become an effective support system for patients

Objective:

Families are able to care for family members who experience self-care deficits

Nursing actions:

a) Discuss perceived problems in caring for self-care deficit patients

b) Explain the meaning, signs and symptoms, and the process of developing self-care deficits and making decisions about caring for the patient
c) Discuss with the family about the personal hygiene facilities needed by the patient to maintain the patient's self-care.
d) Train the family how to care for and guide personal hygiene, dress up, eat and drink, defecate and urinate patients.
e) Family practice creates a family atmosphere and environment that supports the patient's self-care.
f) Discuss signs and symptoms of relapse that require immediate referral to a health facility.
g) Encourage follow-up to health care facilities on a regular basis.

d. Evaluation of Patient and Family Ability to Overcome Self-care Deficits

1) Evaluation of the patient's ability, the patient can:
    - Take a shower, wash your hair, brush your teeth and cut your nails properly and cleanly
    - Change clothes with clean clothes
    - Cleaning dirty clothes
    - Dress properly
    - Preparing food
    - Take food and drink neatly
    - Use cutlery and drink properly
    - Elimination in place
    - Urinate and defecate cleanly.
2) Evaluation of family capabilities, families can:
    - Recognize perceived problems in caring for patients (definition, signs and symptoms, and causes of self-care deficits and consequences if self-care deficits are not resolved)

- Provide personal hygiene facilities needed by patients
- Caring for and guiding patients to take care of themselves: personal hygiene, dressing (women), shaving (men), eating and drinking, defecating and urinating.
- Follow up to health care facilities and recognize signs of relapse and referrals.

SUMMARY

Self-care deficit is a condition in which a person has a disorder ability to perform or complete life activities independently every day. There is no desire of the patient to take a bath regularly, not combing hair, dirty clothes, body odor, bad breath and untidy appearance. Self-care deficit is one

problems that arise in patients with mental disorders. Predisposing factors include biology, where self-care deficits are caused by presence physical and mental illness caused by the client's disability perform self-care and due to factors hereditary where there are family members who experience it mental disorders. Psychologically, there are developmental factors that play a role

no less important, this is because the family too protect and pamper the individual so that the development of the initiative is disrupted. Experienced client's self-care deficit due to limited reality abilities lacking which causes the client not to care about themself and environment including self-care. Social, deficit of social support and environmental situations that are results in decreased ability to care for oneself. Precipitation factors that cause deficits self-care namely decreased motivation, cognitive/perceptual impairment, anxious, tired, weak which causes individuals to be less able do self-care.

REVIEW QUESTIONS

1) Explain the predisposing and precipitation factors of self-care deficit?
2) Describe the signs and symptoms of self-care deficit?

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CHAPTER XII
NURSING CARE OF THE MENTAL THROUGHOUT THE SPAN OF HUMAN LIFE

LEARNING OBJECTIVE

After studying this subject, students will be able to do the following:

1. Identifying the developmental stages in the span human life
2. Constructing the process of the mental throughout the span of human life
3. Nursing planning care in individual with the mental throughout the span of human life

INTRODUCTION

The standard of nursing care for mentally healthy clients refers to the grouping of 8 stages of psychosocial development according to Erickson. These developmental stages include: the development of infants, children, preschool, school age, adolescents, young adults, adults and the elderly.

PREGNANT MOTHER

Changes in pregnancy will certainly cause specific symptoms according to the stages of pregnancy. Therefore, it is hoped that pregnant women can face and be able to adapt to any physiological and psychological changes within themselves realistically without any pressure, by improving their physical and psychological health (Sherwen et al., 1999). The results of the study reported that the stress of pregnant women will affect the increase in mortality rates in infants, children and adults including impaired cognitive, emotional, neurodevelopmental and physiological functions of a person (O'Connor et al., 2002).

Pregnancy in a psychologically healthy woman is an expression of her sense of self-realization and identity as a woman. Pregnancy according to some women is also a positive growth experience for preparation for becoming parents. In some cases, it has also been reported that going through pregnancy is a creative experience capable of satisfying the basic needs of a woman, because this experience is impossible for men to experience (Caplan & Saddok, 1997., Weist & Lederman 2009).

Pregnancy can be seen by women as a way of proving themselves to reassure themselves and at the same time dispelling doubts that they can become pregnant. During pregnancy, a mother will collect various experiences related to her own development. This is done to reduce unconscious fears and fantasies about the experiences that will be faced in giving birth to the baby. Because of that, sometimes there are various negative behaviors towards pregnancy accompanied by fear of having a baby or the role of being a mother.

The health of pregnant women has a significant effect on the growth and development of children. Although there have been efforts to improve maternal health through various government programs, these efforts have only touched on the physical aspects and have not yet focused on efforts to improve the psychosocial and psychological aspects of pregnant women. This is important because the cognitive and emotional growth and development of children is closely related to the psychological problems of the mother during pregnancy. Readiness to become parents is needed before the child is born. The mental attitude of the husband and wife in welcoming the presence of children and how they will carry out their role as parents, will greatly help determine the health of the child both physically, mentally and socially in the future.

Efforts that can be made include creating a supportive environment for the health of pregnant women, changing negative behavior, and increasing awareness of pregnant women and their

families about the importance of both physical and psychological health during pregnancy. One effort that can be done is an information dissemination program with the aim of educating individuals with physical and emotional problems so that they are able to maintain homeostasis against unexpected changes or events that occur gradually to help its members deal with stress in life, focusing on dysfunctional feelings, thoughts and behavior in pregnancy. Pregnancy is a series of sperm cells meeting with healthy eggs and continues with fertilization, nidation, and implantation (Sulistyowati, 2012). Pregnancy begins with the presence of a fetus in a woman's uterus as a result of conception which lasts from the event the product of conception implants in the endometrial wall in the uterus until the birth of the fetus (Keliat, et al., 2021). During this time, a mother learns to understand and respond positively to physiological, psychological and social changes during her pregnancy.

Signs and symptoms

First trimester

Subjective:

1. No menstruation
2. Want to always be cared for by husband and family
3. Feel happy with pregnancy
4. Feel comfortable and happy when touched, caressed and loved by the husband
5. Feeling feelings that change from time to time
6. Response to changes that occur: nausea and vomiting in the morning, tired and sleepy, frequent urination, breasts feel full, do not like the smell of certain foods

Objective:

1. Areola mamae black
2. Positive pregnancy test

Second trimester
Subjective:

1. Afraid if the husband leaves the house in a relatively long time
2. Begin to feel fetal movement
3. Feel happy and happy with the movement of the fetus
4. Feel a bond with the fetus

Objective:

1. Stomach feels distended
2. Enlarged breasts

Third trimester
Subjective:

1. Feeling discomfort in the body: shortness of breath, tired easily, leg cramps
2. Feeling hot, sweating easily, frequent urination, shortness of breath, fatigue, leg cramps
3. Imagine your birthday with joy
4. Find information from many sources about pregnancy, birth and fetus
5. Decide on an alternative place for delivery

Objective:

1. Yellow discharge from the nipples
2. Preparing all the material and spiritual needs of the baby (best name, place of birth, birth ceremony, baby and mother equipment, etc.)

Nursing Care Goals
In pregnant women:

1. Cognitive: pregnant women are able to understand
   a. Normal development in pregnant women
   b. Aberrant development in pregnant women
   c. How to adjust to biological, psychological and social changes during pregnancy

2. Psychomotor: pregnant women are able
    a. Adapting to biological, psychological and social changes
    b. Stimulate the growth and development of the fetus
    c. Conduct pregnancy and delivery examinations at health care facilities
3. Affective: pregnant women feel happy and accept their pregnancy

In the family:

1. Cognitive: the family is able to recognize
    a. Normal development of pregnant women
    b. Aberrant development of pregnant women
2. Psychomotor: the family is able to provide support to pregnant women
3. Affective: the family is able to provide happiness and motivation to pregnant women

Nursing actions

Actions on Pregnant Women:

1. Discuss the normal development experienced during pregnancy
2. Discuss about the aberrant development experienced during pregnancy
3. Discuss the biological, psychological, and social changes in pregnancy
4. Discuss how to achieve normal fetal growth and development with bonding and how adaptation and attachment are achieved

Actions on the Family:

1. Explain the normal development of pregnant women
2. Explain about deviant development of pregnant women

3. Discuss about the biological, psychological and social changes of pregnant women and ways of adaptation
4. Help families provide support during pregnancy and after delivery
5. Discuss with the family about health checks during pregnancy, at least four times during pregnancy
6. Discuss with the family about health service facilities that can be used to carry out health checks during pregnancy and childbirth

BABY STAGE (BASIC TRUST vs. MISS TRUST)

The stage of development for babies aged 0-18 months where at this age babies learn to trust and distrust. This period is the first crisis faced by infants.

Behavioral Characteristics

1. Crying when abandoned by his mother
2. Cry when wet, hungry, thirsty, cold, hot, sick.
3. Resists or cries when being picked up by someone he doesn't know
4. Immediately silent when picked up, cuddled or cradled
5. When crying easily persuaded to be quiet again
6. Hide your face and don't cry immediately when you meet someone you don't know
7. Listen to music or sing happily
8. He turned to find the source of the sound when his name was called
9. When invited to play shows a happy face
10. When presented with a toy grabs the toy or pushes and slams it.

Nursing diagnoses

Readiness increased infant development

Nursing Intervention

1. Immediately hold, hug and rock the baby when the baby cries

2. Meets the basic needs of the baby (hunger, thirst, wet, sick)
3. Give a blanket when the baby is cold
4. Invites to talk to the baby
5. Call the baby by name
6. Invite the baby to play (make funny sounds, move objects, show interesting-colored objects, sound objects)
7. Families are patient and do not take out their frustration or anger on the baby
8. Immediately take the baby to the health care center if the baby has health problems or is sick.

TODDLER STAGE (AUTONOMY vs. DOUBT)

The stage of development of children aged 1.5–3 years where at this age children will learn to do everything related to their needs independently (autonomy).

Behavioral Characteristics

1. Children know their own names
2. Children ask everything that is new or unfamiliar to them
3. Children do their own activities and do not want help
4. Children often say “no” or “don’t”
5. Children begin to get along with other people and want to separate from their parents
6. Children begin to learn to participate in religious activities
7. Shame occurs when a child is clearly aware of himself or herself because of negative exposure
8. Children’s doubts will develop if parents clearly embarrass/embarrass children in front of other people, so parents should be able to provide a wise attitude when children go through this period

Nursing diagnoses

Readiness increased toddler development

Nursing Intervention

1. Provide toys according to child development
2. Train and guide children to carry out activities independently
3. Praise the child's success
4. Does not use command sentences but provides alternative choices
5. Do not vent anger or frustration in the form of physical abuse on children (hitting, grabbing, kicking, etc.)
6. Involve children in family religious activities
7. Avoid situations that can make children feel insecure (scare, surprise, negative sentences, criticize)
8. If a child throws a tantrum, protect him from the danger of injury, falling, getting hurt
9. Guiding children to urinate/defecate in the toilet

PRESCHOOL STAGE (INITIATIVE vs. GUILT)

The stage of development of children aged 3-6 years where at this age children will learn to interact with others, fantasize and take initiative, recognize gender identity, imitate.

Behavioral Characteristics

1. Children like to imagine and be creative
2. Children have the initiative to play with tools at home
3. Children like to play with peers
4. Children easily part with parents
5. Children understand what is right and what is wrong
6. Children learn to string words and sentences
7. Children know different colors
8. Children help do simple household chores
9. Children know their gender
10. Learn new skills through play

Nursing diagnoses

Readiness for increased pre-school age development

Nursing Intervention

1. **Fulfillment of optimal physical needs**
    a. Assess the fulfillment of the child's physical needs
    b. Advise the provision of food with a balanced nutrition
    c. Assess administration of vitamins and repeat immunization (booster)
    d. Teach personal hygiene
2. **Develop gross and fine motor skills**
    a. Assess the child's gross and fine motor skills
    b. Facilitate children to play using gross motor skills (chase, skateboards, bicycles, soccer, catch balls, etc.)
    c. Facilitate children for activities using fine motor skills (learning to draw, write, color, arrange blocks, etc.)
    d. Creating a safe and comfortable environment for children to play at home
3. **Develop language skills**
    a. Assess the child's language skills
    b. Give children the opportunity to ask questions and tell stories
    c. Frequent communication
    d. Teach children to learn to read
    e. Learn to sing
4. **Develop psychosocial adaptation skills**
    a. Assess children's psychosocial adaptation skills
    b. Give children the opportunity to play with peers
    c. Give encouragement and opportunity to enter the competition
    d. Train children to relate to other people who are more mature
5. **Form identity and roles according to gender**
    a. Assess identity and roles according to gender

b. Teach to recognize the parts of the body
c. Teach to know your own gender and distinguish it from the sex of other children
d. Provide gender-appropriate clothing and toys

6. **Develop intelligence**
   a. Assess the development of children's intelligence
   b. Guide children with their imagination to explore creativity, tell stories
   c. Help your child learn new skills
   d. Give opportunities and guide children to help do simple household chores
   e. Teach recognition of objects, colors, letters, numbers
   f. Practice reading, drawing and arithmetic
7. **Develop moral values**
   a. Assess the moral values that have been taught to children
   b. Teach and practice applying positive religious and cultural values
   c. Introduce children to which values are good and which are not
   d. Give praise for the positive values that children do, practice discipline
8. **Increasing family participation in increasing growth and development**
   a. Ask about the condition of the child's growth and development
   b. Ask the efforts that have been made by the family towards the child
   c. Provide reinforcement for the positive efforts that have been made by the family
   d. Encourage families to take their children regularly to health facilities (public health center)
   e. Advise the family to provide a balanced nutritious diet

f. Provide health education about normal developmental tasks at preschool age
g. Provide information on how to stimulate development at preschool age

SCHOOL AGE STAGE (IDUSTRY vs. INVERIORITY)

The stage of development of children aged 6-12 years where at this age children will learn to have the ability to work and acquire adult skills, learn to master and complete their tasks, be productive in learning, enjoy competing at work and feel proud in the success of doing something good. Can distinguish something good/not and the impact of doing something good/not.

Behavioral Characteristics

a. Able to complete assignments from school/home
b. Having a sense of competition, for example wanting to be smarter than friends, winning first place
c. Engage in group activities
d. Begin to understand currency values and units
e. Able to complete simple household chores such as making bed, sweeping etc.
f. Have certain hobbies, for example riding a bicycle, reading story books, drawing
g. Having close friends to play with
h. There were no signs of abuse

Nursing diagnoses

Readiness for increased school-age development

Nursing Intervention

1. **Maintain optimal fulfillment of physical needs**
   a. Assess the fulfillment of the child's physical needs
   b. Advise the provision of food with a balanced nutrition
   c. collaboration of vitamin administration and revaccination (booster)

d. Teach personal hygiene

2. **Develop gross and fine motor skills**
    a. Assess the child's gross and fine motor skills
    b. Facilitate children to play using gross motor skills (chase, skateboard, bicycle, soccer, catch a ball, jump rope)
    c. Facilitate children for activities using fine motor skills (learning to draw/paint, write, color, make handicrafts such as vases, pencil boxes, lanterns, etc.)
    d. Creating a safe and comfortable environment for children to play
3. **Develop psychosocial adaptation skills**
    a. Assess children's psychosocial adaptation skills
    b. Provide time for children to play outside the house with their group friends
    c. Give encouragement and opportunity to participate in various competitions
    d. Give prizes for achievements
    e. Train children to relate to other people who are more mature
4. **Develop intelligence**
    a. Assess the development of children's intelligence
    b. Discuss strengths and capabilities
    c. Providing good education and skills for children
    d. Provide reading materials and games that enhance creativity
    e. Help your child learn new skills
    f. Involve children in simple household chores
    g. Practice reading, drawing and arithmetic
    h. Sharpen and develop hobbies that children have
5. **Develop moral values**
    a. Assess the moral values that have been taught to children
    b. Teach and practice applying positive religious and cultural values

c. Teach the causal relationship of an action
d. Guide children while watching TV and reading story books
e. Give praise for the positive values that children do
f. Practice discipline

6. **Increasing family participation in increasing growth and development**
   a. Ask about the condition of the child's growth and development
   b. Ask the efforts that have been made by the family towards the child
   c. Provide reinforcement for the positive efforts that have been made by the family
   d. Advise the family to provide a balanced nutritious diet
   e. Provide health education about normal developmental tasks at school age
   f. Provide information on how to stimulate development at school age

ADOLESCENT STAGE (IDENTITY vs. ROLE DIFFUSION)

The stage of development of adolescents aged 12-18 years where at this time adolescents must be able to achieve self-identity including roles, personal goals, uniqueness and self-characteristics. If this is not achieved, adolescents will experience role confusion which will have an impact on the fragility of personality so that self-concept disorder will occur.

Behavioral Characteristics

a. Assess yourself objectively, strengths and weaknesses
b. Hang out with friends, have friends to confide in
c. Participate in routine activities (sports, arts, scouts, recitation, martial arts)
d. Responsible and able to make decisions without depending on parents

e. Finding self-identity, having goals and aspirations for the future
f. Do not become perpetrators of anti-social acts and immoral acts
g. Do not force parents to fulfill excessive and negative desires
h. Be polite, respect parents, teachers and be kind to friends
i. Have significant accomplishments in life

Nursing diagnoses

Readiness to increase adolescent development

Nursing Intervention

a. Facilitating youth to participate in positive and beneficial activities
b. Not limiting or overly restricting adolescents but guiding them
c. Creating a comfortable home atmosphere for the development of talents and personality
d. Provide time for discussion, listen to complaints, hopes and aspirations of youth
e. Do not regard youth as juniors who do not have any ability

YOUNG ADULT STAGE (INTIMACY vs. ABSORPTION OR ISOLATION)

Is the stage of human development that is at 20-30 years and at this age individuals must be able to interact intimately with others (Erickson, 1963). At this time the main emphasis in the development of self-identity to create bonds with others that produce intimate relationships. Adults develop lasting friendships and seek mates or marry and become attached to the original duties of a family. Levinson (1978) says that at this time a person is at the peak of intellectual and physical. During this period the need to seek self-gratification is high. In addition, a person's early adulthood moves through the new adult stage, from assuming a junior role at work, starting marriage and parental roles and starting service to the

community to a more senior place at home, work and in the community. Failure to have close relationships and get a job can cause individuals to distance themselves from society and feel lonely and alone.

Behavioral Characteristics

a. Establish warm and friendly interactions with other people
b. Having a close relationship with certain people (boyfriend, best friend)
c. Forming a family
d. Have a clear commitment to work and interact
e. Feeling able to be independent because it is already working
f. Demonstrate economic, social and emotional responsibility
g. Have a realistic self-concept
h. Like yourself and know the purpose of life
i. Interact well with family
j. Able to overcome stress due to changes in himself
k. Considers social life meaningful
l. Has values that guide his life

Nursing diagnoses

Readiness for increased development of young adults

Nursing Intervention

a. Help individuals choose values and guidelines for life
b. Helping individuals choose jobs according to their talents and abilities/education
c. Guiding in choosing a life partner
d. Encourage active participation in community activities
e. Guiding individuals in making important decisions in life (marrying, having children, creating a new family and home)

ADULT STAGE (GENERATIVITY vs. STAGNATION)

The stage of human development aged 30-60 years where at this stage is the stage where individuals are able to be involved in

family life, society, work, and are able to guide their children. Individuals must be aware of this, if these conditions are not met it can lead to dependency in work and finances.

Behavioral Characteristics

a. Assess life achievements and feel comfortable with life partners
b. Accept the physical and psychological changes that occur
c. Guiding and preparing the younger generation wisely and wisely
d. Adjusting to his elderly parents
e. Creative: having initiative and ideas to do something useful
f. Productive: able to produce something meaningful for himself and others, fill free time with positive and useful things
g. Caring for and caring for others: paying attention to the needs of others.
h. Develop interests and hobbies

Nursing diagnoses

Readiness for increased adult development

Nursing Intervention

a. Describe normal adult development and deviant development
b. Accepting the aging process and changing roles in the family
c. Interact well with your partner and enjoy being with your family
d. Broaden and renew interests/pleasures
e. Utilizing independence and ability/potential in a positive way

ELDERLY STAGE (INTEGRITY vs. ISOLATION)

The stage of human development over the age of 65, where at this stage the individual achieves complete self-integrity, understands the meaning of life as a whole and is able to guide the next generation (children and grandchildren) based on their point of

view. Elderly who do not achieve self-integrity will feel hopeless and regret their past because they do not feel that their life has meaning.

Behavioral Characteristics

a. Have high self-esteem
b. Valuing his life is meaningful
c. Accept the value and uniqueness of others
d. Accept and adjust to the death of a spouse
e. Prepare yourself to accept the coming of death
f. Carry out regular religious activities
g. Feeling loved and meaningful in the family
h. Participate in social activities and community groups
i. Prepare to be abandoned by a child who has become independent

Nursing diagnoses

Readiness to increase the development of the elderly

Nursing Intervention

a. Discuss ways for the elderly to achieve complete self-integrity (discussion about the meaning of life, past achievements, success in educating children)
b. Facilitating community and religious social activities (sports, social gathering, elderly *posyandu*, recitation)
c. Treating the elderly as meaningful parents in the family
d. Fulfilling the needs of love and affection of the elderly
e. Facilitating the elderly with hobbies to fill their time
f. Do not forcefully employ the elderly to become the breadwinner for the family

SUMMARY

The management of mental health nursing in the area of mental health focuses on the stages of psychosocial developmental tasks. Healthy nursing diagnoses, namely readiness to increase the development of pregnant women, infants, children, pre-school,

school, adolescents, adults and the elderly. Nursing care for mental health diagnoses aims to provide the ability for individuals to identify their abilities, overcome the pressures of life, work productively and benefit others.

REVIEW QUESTIONS

1. A woman, 28 years old, a housewife, brings her 12-month-old baby to health service facilities for health checks for growth and development. The results of the Nurse's assessment found no problems and the child was in good health. What behavioral characteristics can the nurse observe based on this case?
   a. Children know their own names
   b. Silence when abandoned by his mother
   c. When crying is difficult to persuade to be silent again
   d. Able to carry out activities on their own and do not want help
   e. Resists or cries when being picked up by someone he doesn't know
2. A boy, aged 2.5 years was brought by his mother to health service facilities for health checks for growth and development. The results of the Nurse's assessment found no problems and the child was in good health. What is Erikson's psychosocial developmental task based on this case?
   a. Initiative vs. Guilt
   b. Autonomy vs. Doubt
   c. Industry vs. Inferiority
   d. Basic Trust vs. Miss Trust
   e. Identity vs. Role Diffusion
3. A boy, 5 years old, was brought by his mother to health service facilities for health checks for growth and development. The results of the Nurse's assessment found no problems and the child was in good health. What is Erikson's

psychosocial developmental task based on this case?

a. Initiative vs. Guilt
b. Autonomy vs. Doubt
c. Industry vs. Inferiority
d. Basic Trust vs. Miss Trust
e. Identity vs. Role Diffusion

4. A woman, a nurse at a health center, a nurse graduate, a mental programmer who manages the Mental Health Alert Village through a community mental health nursing service program. The nurse manages the health of elementary school students in the community. What are the identifiable behavioral characteristics according to the age stages in the case above?
   a. Assess yourself objectively
   b. Likes to fantasize and be creative
   c. Engage in group activities
   d. Ask anything new or unfamiliar
   e. Learn new skills through play
5. A man, 32 years old, married, private employee. The results of early detection of mental health carried out by nurses obtained data that the client was included in the mental health category with a nursing diagnosis of readiness to increase young age development. What nursing actions can the nurse take based on this case?
   a. Create a comfortable home atmosphere
   b. Facilitating social and religious activities
   c. Help individuals choose values and guidelines for life
   d. Provide time for discussion and listening to complaints
   e. Facilitate participation in positive and beneficial activities
6. A woman, 65 years old, widow, retired civil servant. The results of early detection of mental health carried out by nurses obtained data that the client was in the mental health category. What are the behavioral characteristics that are not

appropriate for the age stages in this case?

a. Have high self-esteem
b. Valuing his life is meaningful
c. Accept the value and uniqueness of others
d. Accept and adjust to the death of a spouse
e. Accept the physical and psychological changes that occur

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CHAPTER XIII
NURSING CARE FOR CHILDREN WITH SPECIAL NEEDS

LEARNING OBJECTIVE

After studying this subject, students will be able to do the following:

1. Organizing the definition of children with special needs
2. Constructing the process of children with special needs
3. Nursing planning care in patient with children with special needs

INTRODUCTION

Developmental and behavioral disorders in children are often not handled properly and recognized as early as possible in society. The family will go to a health service if the family is unable to deal with behavior in children. The results of studies on the global burden of disease show that by 2020 the number of neuropsychiatric cases in children will increase by >50% and become one of the five diseases with morbidity, mortality and disability in children worldwide (Muray & Lopez, 1996; Mental Health America, 2011). One in five children who experience clinical problems with mental health disorders, only one third receive treatment (Kluger, 2010). Half of all cases of mental disorders that affect all ages begin at the age of 14 years (Kessler et al., 2009). Mental disorders that develop before the age of 6 years can affect critical aspects of a child’s emotional, cognitive and physical development. Prevention, identification and early treatment of children at risk are very important to reduce the risk of developing mental disorders when they reach adulthood.

EGO COMPETENCY SKILLS IN CHILDREN

1. Develop a relationship of closeness and trust
2. Ability to make decisions separately and independently
3. Negotiation skills in joint decision making and interpersonal conflict
4. Ability to deal with disappointment
5. Shows happy feelings and happy experiences
6. Work to delay gratification
7. Relax and play
8. Development of cognitive processes through words, symbols and pictures
9. Develop an adaptive sense of direction and direction

CHILD MENTAL HEALTH ASSESSMENT

Interview with family: determine family and developmental problems (genogram), mental and physical health conditions of parents and family interaction.

Interview with child: mental health status, assess the development of awareness and values, physical examination

Inspection other: school (friends, play, bullying, academic), psychological test (IQ), neuroimaging, encephalogram

MENTAL HEALTH DISORDERS IN CHILDREN

Children with mental disorders experience neglect of symptoms that arise related to biological changes, traumatic situations or maladaptive learning processes. Children usually also experience some of the symptoms of mental disorders that are common in adults. The most common mental disorders in children: attention hyperactivity disorder (ADHD), depressive disorders, mental retardation, anxiety, conduct disorders and autism.

Mental retardation: failing to use social interaction behaviors, dysfunction of interaction with others and shows discomfort in social situations.

Autism: less concerned about other people, don’t want to be hugged, indifference or aversion to affection and physical contact, not able to play together and make friends, limited attention span, easy activity switching.

ADHD: impulsive, difficulty forming satisfying interpersonal relationships, disturbing behavior, difficulty conforming to social norms.

NURSING DIAGNOSES

1. Risk to injure yourself, others
2. Situational and chronic low self-esteem
3. Damage to social interaction
4. Ineffective coping
5. Anxiety
6. Self-care deficit
7. Readiness for improved family processes

NURSING IMPLICATIONS

Mental Retardation

1. The need for security must be closely monitored
2. Self-esteem is usually low and requires re-evaluation and reinforcement
3. Higher functional children usually have a sense of humor and some of them have rich life fantasies

The Role of Nurses in the Prevention of Mental Retardation

Prevention Primary: prevention pregnancy young on teenage girl, parent consultation, pregnant women are at risk

Prevention secondary: assessment against risk needs and problem on children & family

Health promotion: health education to parents and child

Four main things of health education in mental retardation children: using stimulation, giving real directions so that children can

follow, gives the opportunity to make decisions, teaches children to choose alternatives when making decisions.

Support to family: helping family members to go through the grieving process so you can adapt

give opportunity to ask, nurses must be sensitive to people's emotional needs old and provide support right.

ADHD

1. It is important for nursing planning to be based on various sources of data and references
2. Talking to the child and parent separately can sometimes help
3. Negativistic behavior is always a major challenge

Communication strategy: prevent the client from being able to interrupt while the nurse is speaking by providing prompt feedback and helping the client set realistic goals for behavior change, asking the client to stop what they are doing, looking at the speaker and focusing on what the speaker is saying and using verbal commands to ask the client to carry out tasks/stop inappropriate behavior, speak calmly but firmly when conditions are limited, use short and simple sentences.

Treatment for ADHD generally focuses on reducing symptoms. The most effective therapy is drug therapy, individual therapy and family therapy.

Individual therapy: help clients develop trust, help the development of client self-esteem, help clients develop verbal and nonverbal communication skills, help clients improve impulse control (push from within), help clients relieve depression associated with negative self-image, help clients reduce social isolation caused by feelings of being different from other children

Play therapy: provide a tool the client can use to communicate ideas and feelings that cannot be expressed, help do some environmental control, use play to solve problems or try to practice solutions to deal with stressful situations.

Special education: consult with school officials regarding the goals of combining special education methods with behavior modification techniques, arrange for the client to be in a structured class setting with frequent repetition of material to be studied, give clients available resources so that complex tasks can be divided into small units, if possible, let the client go back to the study module if the client has a few difficult days.

Treatment: stimulant drugs are effective in more than 70% of children with ADHD, antipsychotic drugs and tricyclic antidepressants relieve some of the symptoms and stabilize mood.

Family upbringing: tell parents about the causes and treatment of ADHD, develop a consistent plan of intervention, teach child behavior management techniques, discuss how to reduce the possibility of injury/damage to property, explore the impact of having an ADHD child in the family,

tell the family about the ministry, focus on strengthening the communication patterns and assets of each family member, support positive parental involvement in children's school and social life, encourage parents of children with ADHD to participate in support groups.

Autism

1. The three areas where children suffer damage are communication, social skills and repetitive patterns of behavior
2. The child may use inappropriate language and ask personal questions that require attention

Behavior modification therapy: focus only on inappropriate behavior, not on any emotional upset that may be present, provide positive feedback and rewards for appropriate behavior. Ignore negative behavior, such as temper tantrums, if they are not destructive/life-threatening.

Milieu therapy (social environment): provide repetitive experiences that are common to everyday life, such as maintaining

a fixed schedule of grooming and play activities, control the environmental stimulus as much as possible to minimize changes around the client, reduce and change disruptive behavior by keeping tasks simple that do not require complex social language/abstract thinking skills.

Play therapy: investigate the client's view of the world and current environment as a way of developing structured interactions and practicing social skills through play, provide positive reinforcement for appropriate behavior.

Treatment: several drugs (antipsychotics, CNS stimulants and antidepressants) can be given to relieve anxiety, severe psychomotor agitation and extreme sensitivity to environmental stimuli. These drugs do not significantly relieve autism symptoms.

Family upbringing: provide anticipatory guidelines for parent-child interactions, discuss how to deal with the child's disruptive behavior, facilitate discussions about family guilt and shame, prevent family from social isolation, encourage parents to focus on their own and their child's needs, help parents to express grief.

CHILD BEHAVIOR MANAGEMENT STRATEGY

1. Give a conducive response to the child's positive behavior
2. Communicate with verbal and non-verbal language
3. Show joy when your child achieves an achievement
4. Ignore negative behavior when appropriate
5. Avoid giving unnecessary instructions
6. Respond calmly and effectively to any negative behavior displayed
7. Use the time lag if needed and according to conditions
8. Avoid making unrealistic expectations of your child
9. Avoid giving negative judgments to children

SUMMARY

Children with special needs, parents and siblings need comprehensive information and support from nurses. Our nursing care may not be able to return the condition of children with special needs back to being children in general, but can improve the quality of life of children and achieve optimal child development actualization. Children with special needs are children who experience physical, developmental and behavioral or emotional conditions that require it related health services in more types or quantities than the child needs others in general. Children with special needs can be classified into several including attention deficit and hyperactivity disorder (ADHD), autism, and mental retardation.

REVIEW QUESTIONS

1. Basically, there is no single theory that can completely explain the development of the child's soul. Therefore, in psychiatric nursing for children, an approach that focuses on?
    a. The structure of behavior patterns
    b. Cognitive aspect growth
    c. Ego competency skills
    d. Ego beliefs and rational elements
    e. Physical growth and life experiences
2. Hyperactive/impulsive behavior in children with Attention Deficit Hyperactivity Disorder (ADHD), namely?
    a. Difficult to manage
    b. Invisible listening
    c. Difficulty sustaining attention
    d. Annoying siblings/playmates
    e. Not completing assignments or homework
3. One of the limitations of the characteristics of individual coping nursing diagnoses is ineffective in children with Attention Deficit Hyperactivity Disorder (ADHD), namely?
    a. Insensitive to pain

b. Overreaction to environmental changes
c. Inability to concentrate/finish tasks
d. Avoiding new stimuli followed by impulsive behavior
e. Amazed and eager to touch the moving and dangerous parts of the machine

4. The main goal of nursing in mentally retardation is?
   a. Meet the health needs of mentally retarded children
   b. Prevention of disease and restoration of function and health of children
   c. Identify developmental delays that may have occurred
   d. Provide opportunities for children and families to improve their health
   e. Know the signs and symptoms in children who have the potential to experience developmental disorders
5. The role of nurses in preventing mental retardation is by means of secondary prevention by means of?
   a. Parent consultation
   b. Immunization program and healthy children program
   c. Health education for parents and children
   d. Prevention of early pregnancy in teenage girls
   e. Assessment of risks, needs and problems in children and families

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CHAPTER XIV
NURSING PROCESS WITH DRUGS ABUSE

LEARNING OBJECTIVE

After studying this subject, students will be able to do the following:

1. Organizing the definition of drugs abuse
2. Constructing the process of drugs abuse
3. Nursing planning care in patient with drugs abuse

INTRODUCTION

The prevalence of drug abuse cases continues to increase both globally and nationally. A drug abuse has affected all levels of society regardless age, education and socioeconomic groups. Government and all society have tried to eradicate the circulation of illicit substances but until now cases are still quite high. The impact of drug abuse is the emergence of maladaptive behavior and disorders personality traits such as withdrawal, hallucinations and violent behavior. Because of that impact caused by drug abuse is very complex, a nurse is needed who are able to provide nursing care to patients with drug abuse.

A. DEFINITION

Drug abuse refers to the use of substances on a continuous basis until after the problem occurred. Drug abuse including alcohol, opium, drugs with prescriptions, psychotomimetic, cocaine, marijuana. A serious and growing problem in substance abuse is increasing the use of more than one type of substance simultaneously or sequentially. Individual will experience a state of relaxation, euphoria, stimulation, or a change of consciousness with various ways

B. TYPE OF DRUGS ABUSE

Various types of substances circulating in society and widely used by users Among them are depressants, marijuana, stimulants, opiates, hallucinogens, phencyclidine (PCP). Depressants circulating in the community include alcohol, and barbiturates. One of the marijuana groups is Acapulco gold. Whereas for the stimulant class is divided into amphetamine and cocaine. The opiates include heroin, morphine, meperidine, codeine, opium, methadone. The hallucinogen group is, mellow yellows and the penicillin group is angel dust and DOA.

C. CHEMICAL RESPONE RANGE

Not all Individuals who use substances will be drug abuse and dependence. But only individuals who use substances in excess may result in misuse and drug dependency. Drug abuse is the continuous use of substances even after a problem occurs. While substance dependence shows a condition is severe and is often considered a disease. Withdrawal symptoms occur because biological need for drugs. Tolerance means an increase in the amount and dose of drug to get the expected effect.

D. NURSING PROCESS

1. Assessment

Assessment of someone with substance abuse is usually caused by some things like:

a. Individual factors

Individuals with low self-esteem, easily disappointed, like to try experimenting and being antisocial, risking abuse substances (drugs).

b. Environmental factor

An unfavorable social environment can encourage someone to do it substance abuse (drugs), for example communication in families that are not close, peer groups who

use drugs and the number of places to get drugs easily. In addition, supervision from the community lax, for example laws that are not firm lead to illegal drug trafficking continues.

c. Substance factor
   1) The substance itself provides enjoyment, its ease of obtaining and its price affordable, obtained free of charge/without spending money.
   2) High-risk situations for using drugs are emotional states unstable, conflict with others, and social pressure.

d. Coping source

   What is really needed to help individuals free from substance abuse namely the individual's ability to carry out effective communication, skills apply an assertive attitude in everyday life, the need for social support strong, giving alternative fun activities, skills to do stress reduction techniques, work skills and motivation to change behaviour.

e. Coping mechanism

   Individuals with substance abuse often experience failure to cope problem. Healthy coping mechanisms and individuals are not able to develop adaptive behavior.

f. Typical ego defense mechanisms used in substance abuse individuals

   includes denial of the problem, rationalization, projection, not responsibility behavior, and reducing the amount of alcohol or drug use.

Table 1. Signs and Symptoms of Intoxication

Signs and Symptoms of Intoxication				
Opiates	Cannabis	Sedative-Hypnotic	Alcohol	Amphetamines
• Euphoria • sleepy • slurred speech • constipation • decline • awareness	• euphoria • red eye • dry mouth • talk too much • and laughed	• self-control • reduce • road • staggered • sleepy • •extend • Sleep	• red eye • slurred speech • road • staggered • change • perception	• always • pushed • for • move • sweating • shiver • worried

Signs and Symptoms of Intoxication				
Opiates	Cannabis	Sedative-Hypnotic	Alcohol	Amphetamines
	• appetite • increase • perception disorder	• loss of consciousness	• decline • ability evaluate	• depression • paranoid

Table 2. Signs and Symptoms of Withdrawal

Signs and Symptoms of Withdrawal				
Opiates	Cannabis	Sedative-Hypnotic	Alcohol	Amphetamines
• painful • eyes and • runny nose • feeling • chills • diarrhea • nervous • can't • Sleep	• seldom • found	• anxiety • hand • shiver • change • perception • disturbance • memory • can't • Sleep	• anxiety • depression • red face • easy to get angry • hand • shiver • nauseous vomit • can't sleep	• anxiety • depression • fatigue • energy • reduce • need • sleep • increase

Table 3. Assessment on Drugs Abuse

Assessment	Intoxication	Withdrawal	Overdoses
Sedative-Hypnotic (depressant)	1. Decreased mental function : decrease in ability understand, glitches memory, decline taking ability decision, sleepy, reduced attention or limited 2. Impaired coordination motor: emphasis speech, ataxia, hyperreflexia,	1. decrease in level awareness 2. decrease or no response against pain 3. Respiratory depression 4. Slow breathing, apnea 5. imbalance fluids and electrolytes	1. Psychological Response 2. Easy withdrawal: acute anxiety, irritability, nervousness, trouble concentration, insomnia nightmares (nightmares) 3. Heavy withdrawals: Disorientation, delirium, paranoia, violence, fear, depersonalization.

Assessment	Intoxication	Withdrawal	Overdoses
	reaction increase 3. Euphoric mood, labile, decrease in anxiety 4. Inhibition 5. Cranial nerve dysfunction: nystagmus, diplopia 6. Decreased pulse, pressure drop blood and respiration		4. Physiological Response 5. tremor, tachycardia, headache, irritability, anxiety, postural hypotension, insomnia, cold sweats, deep tendon hyperreflexia reflexes, disorientation. 6. Generalized seizures 7. Myoclonic contractions 8. Hallucinations usually hearing 9. Delirium, damage long term memory and now, disoriented visual hallucinations, hearing and touch 10. Hypertension 11. Diarrhea 12. Hyperpyrexia, diaphoresis 13. Collapse of blood vessels
2. Stimulants (amphetamine and cocaine)	1. Psychotic inhibition : anxiety, internal limitations taking decision, impulsive, hypersex 2. Clear sensory appearance	1. hyperactivity, anxiety, 2. confusion hallucinations 3. Paranoid (can develop be delirium, panic attack, delusional suspicious violently	Psychological Response 1. Crash phase: depression, agitation, high drug craving, fatigue, desire to sleep, and no drug cravings 2. Withdrawal

Assessment	Intoxication	Withdrawal	Overdoses
	confusion and hallucinations, decline fatigue, desire high, increase interest in environment, self-esteem increase. 3. Increased activity psychomotor, tremors 4. increased pulse and blood pressure 5. decreased appetite Eat 6. mydriasis	and behavior attack 4. Seizures and coma 5. diaphoresis and hyperpyrexia 6. tachycardia hypertensive crisis with vasoconstriction extreme	phase: anhedonia, anergia, anxiety and really need cocaine Physiological Response 1. myocardial ischemia 2. acute dystonia
3. Narcotics	1. Euphoria with change sensory perception, bad understanding, memory impairment 2. drowsiness, decline social interactions 3. Miosis, pupil contraction abnormal 4. Mild hypotension with tachycardia, decline respiration.	1. Degrade awareness 2. Respiratory depression grow to apnea and respiration arrest 3. bradycardia, hypotension, shock 4. Gastrointestinal atony	Psychological 1. Anxiety, restlessness, dysphoria, mood and sleep disturbances Physiological 1. Cramps in the stomach, nausea and vomiting 2. Diaphoresis 3. hypertension 4. Pain in the muscles and back 5. The hair on the neck stands up 6. Yawning 7. Mydriasis 8. Diarrhea
4. Alcohol	1. Psychological inhibition: anxiety, limitations in taking	1. Respiration decreased 2. feeling cold 3. Moist skin 4. Pupils constrict	1. Restless, irritable, anxiety, agitation 2. Anorexia, nausea, vomiting

Assessment	Intoxication	Withdrawal	Overdoses
	decision, impulsive, hypersex 2. Clear sensory appearance confusion and hallucinations, decline fatigue, desire high, increase interest in the environment, improvement pride. 3. Increased activity psychomotor, tremors 4. increased pulse and blood pressure 5. decreased appetite 6. mydriasis		3. Tremor, Increased pulse, increase in blood pressure 4. Insomnia, frequent dreams bad 5. Damage to concentration, memory and retrieval decision 6. increased sensitivity to sound, change touch sensation 7. Delirium (time disorientation, place and person) 8. Delusions are usually paranoid 9. Grand mal seizures 10. Increase in temperature
5. Opiate	1. Euphoria with sensory changes perception, understanding bad, distraction memory 2. drowsiness, decline social interactions 3. Miosis, pupil contraction abnormal 4. Mild hypotension with tachycardia, decreased respiration.	1. Degrade awareness 2. Respiratory depression grow to apnea and respiratory arrest 3. bradycardia, hypotension, shock 4. Atony gastrointestinal	Beginning 1. Anxiety 2. insomnia 3. Increased breathing 4. Sweating 5. Lacrication 6. evaporate 7. rhinorrhea (runny nose) 8. Piloerection (goosebumps) 9. restless 10. anorexia 11. irritability 12. Dilated pupils Carry on 1. Insomnia 2. nausea and vomiting 3. diarrhea

Assessment	Intoxication	Withdrawal	Overdoses
			4. weakness 5. abdominal cramps 6. tachycardia 7. hypertension 8. Muscle spasms 9. Muscle and bone pain
6. Marijuana	1. Changes to flavour 2. decline ability concentrate, passive, lethargic, breakdown term memory short, sleepy or hyperactivity, sensory changes perception. 3. Tachycardia with orthostatic hypotension 4. Conjunctival infection, nystagmus 5. increased appetite Eat 6. Dry mouth	1. Anxiety reaction or panic 2. depersonalization 3. Delusions of paranoid	1. Irritable 2. difficulty sleeping 3. Same as cocaine
7. Inhalants	1. euphoria, dizziness, excitement, pleasant exhilaration, hallucinations vision and hearing 2. sneeze 3. Nausea and vomiting	1. Confused, lacking self-control, decreased consciousness, seizures 2. headaches, tinnitus, blurred vision, diplopia, nystagmus 3. Disorganization muscle, stress	Same with alcohol

Assessment	Intoxication	Withdrawal	Overdoses
		talk, decline reflex 4. cardiac arrhythmia, pulmonary oedema 5. suicidal ideation	

2. Nursing Diagnosis

Based on the results of the assessment, nursing diagnoses can be enforced are: Ineffective individual coping

3. Nursing Actions

Nursing actions for patients:

a. Objective
   1) Patients can overcome the signs and symptoms of intoxication or withdrawal
   3) Patients can recognize the impact of substance use
   4) Patients can increase motivation to stop using substances
   5) Patients can control the desire to use substances
   6) Patients can improve the ability to solve problems
   7) Patients can change lifestyle
   8) Patients can use psychopharmacological therapy appropriately and correctly

b. Action
   1) Discuss with the patient about the impact of substance use on:
      a) Health: signs and symptoms of intoxication and physical illness
      b) Social or relationships with other people (association)
      c) Education or employment
      d) Economics or finance
      e) Law
   2) Discuss about the patient's life before using the substance, then hope patient for life now and in the future after knowing

3) Discuss how to increase motivation to quit
   a) Positive things that the patient still has (health/association/education/work/economy/law), for example the patient is still physically strong, nothing complications from substance use
   b) Train the patient to be grateful for the situation
      (1) List things for which you should be grateful more often (affirmation exercise)
      (2) Repeat the desire to quit (affirmation exercise)
4) Discuss how to control the desire to use substances by:
   a) Avoiding, for example: not going to places where there are dealers, no passing through places that have memories of using substances, no join/associate with users
   b) Divert, for example: busy yourself with busy activities and pleasant.
   c) Refuse, for example: say no, even though it is offered free of charge and still say no, even once.
   d) Train the patient to control the desire to use substances
      (1) Evade
      (2) Divert
      (3) Refuse
5) Discuss healthy ways of solving problems
   a) Recognize how the patient has solved the problem so far, for example immediately use substances when there is a problem
   b) Profit and loss method is used
   c) Offer healthy ways to solve problems, for example:

(1) Verbal: if the patient is often suspected and accused of using drugs by then the patient's parents revealed that the patient was disappointed yet trusted by the family, then talk to the parents that distrust is upsetting and can

lead to suggestions, say things that are expected of others honestly and open, agree with the parents if the patient will say directly be honest with the family if the patient turns out to use it again, and the family will help patients to get treatment

(2) Physically: take free time for yourself by walking, engage in activities to channel frustration, such as sports, relaxation or other activities the patient likes

(3) Socially: seek help from others to solve problems

(4) Spiritually: complaining about problems to God and having faith that there will be help from the God

d) Train the patient to use this method by:

(1) Recognize high-risk situations

(2) Negative emotional conditions, for example, annoyed, accused of using again impact.

(3) Conflicts with other people, for example fighting because they are not allowed to go out house or accused of theft

(4) Social pressure, for example forced as a condition to join certain group

(5) Not using substances to solve problems, but Use healthy ways to solve problems.

6) Discuss a healthy lifestyle

a) Eat and poop regularly

b) Work and sleep regularly

c) Maintain personal hygiene

d) Train the patient to change lifestyle

(1) Define daily activities and hobbies

(2) Make a schedule of activities

(3) Determine the implementation of the schedule

7) Train the patient to take medication according to the doctor's therapy emphasizing the principle of correct dosage the medicine

6. Evaluation of Nursing Care in Drugs Abuse

Evaluation of nursing care in patients with substance abuse requires nurse's attention and alertness. Some questions that can be asked for evaluate the outcome of interventions in patients with drugs abuse.

a. Has the patient achieved the goals set?
b. Can patients communicate effectively without having to defend themselves?
c. Does the patient carry out daily activities without using the drug?
d. Is the patient actively involved in various external social activities?
e. Is the patient able to utilize internal resources consistently in order to productive at work and engage in meaningful interpersonal relationships

SUMMARY

The term substance abuse refers to the continuous use of substances even after the problem occurred. Types of substances circulating in society and widely used by users Among them are depressants, marijuana, stimulants, opiates, hallucinogens, penicclidine (PCP). The range of maladaptive chemical responses includes substance dependency, substance abuse, withdrawal symptoms and tolerance. The assessment of substance-related disorders includes the following factors following, namely behavioral factors, predisposing factors (consisting of biological factors, factors psychological, sociocultural factors); precipitating factor; coping resources, and mechanisms coping.

REVIEW QUESTIONS

Describe substance abuse and identification the types of substances circulating in society!

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CHAPTER XV

THERAPY MODALITIES IN PSYCHIATRIC NURSING

LEARNING OBJECTIVE

After studying this subject, students will be able to do the following:

1. Organizing the definition of therapy modalities in psychiatric nursing
2. Comparing the type of therapy modalities in psychiatric nursing
3. Integrating the therapy modalities in psychiatric nursing
4. Explain the group activity therapy

INTRODUCTION

Modality therapy is the main therapy in mental nursing. Asa therapist, nurses must be able to change the patient's maladaptive behavior into adaptive behavior and increase the patient's potential. There are various therapeutic modalities in psychiatric nursing such as individual therapy, family therapy, play therapy, environmental therapy and group activity therapy. Modality therapy can be carried out individually or in groups or by modifying the environment by changing the entire environment into a therapeutic environment for clients, thus providing clients with opportunities to learn and change behavior by focusing on therapeutic value in activities and interactions.

MODALITY THERAPY

There are several types of modality therapy in psychiatric nursing such as:

1. Individual Therapy

Is a structured relationship that exists between the nurse and the client to change the client's behavior. Where the relationship

that is established is a deliberate relationship with therapeutic goals, it is carried out in systematic (structured) stages so that through this relationship it is hoped that a change in the client's behavior will occur in accordance with the goals set at the beginning of the relationship. This structured relationship in individual therapy aims to enable clients to resolve the conflicts they experience. In addition, clients are also expected to be able to relieve emotional distress, and develop appropriate ways to meet their basic needs. Stages of relationship in individual therapy include:

a. Orientation Stage

The orientation stage is carried out when the nurse first interacts with the client. The first action that must be taken is to build a trusting relationship with the client. A trusting relationship between nurse and client is very important to establish, because with the establishment of a relationship of mutual trust, clients can be invited to express all their problems and cooperate in solving problems experienced, as long as they are in contact with nurses. If the relationship of mutual trust has been well established, the next stage is the client and the nurse discussing what causes the problems that occur to the client, the types of conflicts that occur, also the impact of these problems on the client. The orientation stage ends with an agreement between the nurse and the client about the goals to be achieved in the nurse-client relationship and how the activities will be carried out to achieve these goals.

b. Stages of Work

At this stage the nurse has a very important role as a therapist in providing a variety of nursing interventions. Success at this stage is marked by the nurse's ability to multiply and explore clients to express the problems they are experiencing. At this stage it is also very important for a therapist. At this stage, the client is helped to be able to develop an understanding of himself, and what is happening to him. In addition, clients are encouraged to dare to change behavior from maladaptive behavior to adaptive behavior.

c. The Termination Stage

The termination stage occurs when the client and nurse agree that the problem that initiated the therapeutic relationship has been resolved and the client has been able to change behavior from maladaptive to adaptive. Another consideration for terminating is if the client feels better, there is an increase in self, social and work functions, and the most important thing is that the goals of therapy have been achieved.

2. Environmental Therapy

Environmental therapy is a therapy that is carried out by changing or managing the environment in order to create behavior changes in clients from maladaptive behavior to adaptive behavior. The therapy process is carried out by changing the entire environment into a therapeutic environment for the client. With a therapeutic environment, it will provide clients with opportunities to learn and change behavior by focusing on therapeutic value in activities and interactions. It is very important for a nurse to provide opportunities, support, understanding so that clients can develop into responsible individuals. With environmental therapy clients learn new skills such as obeying applicable rules, besides that clients learn to realize expectations from the surrounding environment that have been agreed upon together and learn to deal with and resolve pressure from peers (peer groups), and learn to interact with others. The ultimate goal of environmental therapy is to increase the client's ability to communicate and make decisions, which in turn increases the client's self-esteem. In addition, environmental therapy teaches how to adapt to a new environment outside the hospital, such as the home environment, workplace and community.

3. Biological Therapy

The application of biological therapy or somatic therapy is based on a medical model in which mental disorders are seen as diseases. The view of this model is different from other therapeutic conceptual models which, because this therapeutic model views that mental disorders are purely caused by mental disorders alone, without considering pathophysiological abnormalities. The therapeutic process is carried out by carrying out specific assessments and grouping symptoms into specific syndromes. Abnormal behavior is believed to result from certain biochemical changes. Several types of somatic therapy for mental disorders such as: administration of drugs (psychopharmaceutical medication), nutritional interventions, electro convulsive therapy (ECT), photo therapy, and brain surgery. Some of the therapies that are still being applied in mental health services include psychoactive medication and ECT.

4. Cognitive Therapy

The principle of this therapy is to modify the beliefs and attitudes that affect the feelings and behavior of the client. The therapy process is carried out by helping find stressors that are the cause of mental disorders, then identifying and changing inaccurate thought patterns and beliefs to become accurate. Cognitive therapy believes that behavioral disorders occur due to inaccurate patterns of beliefs and thinking of clients. For this reason, one of the principles of this therapy is behavior modification by changing these patterns of thinking and beliefs. The focus of care is on helping the client to re-evaluate ideas, values that are believed and hoped for and then proceed with compiling cognitive changes. Giving cognitive therapy aims to:

a. Develop a pattern of rational thinking. Changing irrational thinking patterns that often result in behavioral disturbances into rational thinking patterns based on actual facts and

information.

b. Get used to always using the way of thinking reality in responding to every stimulus so as to avoid distortion of thoughts.
c. Shaping new behavior with internal messages. Behavior is modified by first changing the pattern of thinking. Forms of intervention in cognitive therapy include teaching the client to substitute thoughts, learning problem solving and modifying negative self-talk.

5. Family Therapy

Family therapy is therapy given to all family members where each family member has a role and function as a therapist. This therapy aims to enable families to carry out their functions in caring for clients with mental disorders. For this reason, the main target of this type of therapy is dysfunctional families; namely families who are unable to carry out the functions demanded by its members. In family therapy, all perceived family problems are identified, then each family member identifies the cause of the problem and the contribution of each family member to the emergence of the problem. To then seek solutions to maintain family integrity and improve or restore family function as it should. The family therapy process consists of three stages, namely phase 1 (agreement), phase 2 (work), phase 3 (termination). In the first phase the nurse and client develop a trusting relationship, family issues are identified, and therapeutic goals are set together. Activities in the second phase or work phase are families assisted by nurses as therapists trying to change patterns of interaction between family members, increase the competence of each family member, and explore family boundaries and existing regulations. Family therapy ends in the termination phase where the family is able to solve the problems experienced by overcoming various issues that arise. Families are also expected to maintain continuous care.

6. Group Activity

Therapy Group therapy is a psychotherapy that is given to a group of patients by means of discussion among fellow patients and is led or directed by a therapist or mental health worker who has been trained.

a. Benefits of TAK

In general, group activity therapy has the following benefits:

1) Improving the ability to assess and test reality (reality testing) through communication and feedback with or from other people.
2) Improving patient socialization skills.
3) Raising awareness about the importance of the relationship between one's own emotional reactions with defensive behavior (enduring stress) and adaptation.
4) Generating motivation for the advancement of psychological functions such as cognitive and affective.

In particular, the goals of group activity therapy are:

1) Improving patient identity.
2) Channeling the patient's emotions constructively.
3) Improve social relationship skills that will help patients in everyday life.
4) Rehabilitative in nature: improving self-expression abilities, social skills, self-confidence, empathic abilities, and increasing abilities about life's problems and their solutions.

b. Types of Group Activity Therapy

1) TAK: Perceptual Stimulation

a) Definition:

Group activity therapy (TAK): Perceptual stimulation is therapy that uses activity as a stimulus related to experience and or life to be discussed in a group. The results of the Mental Nursing 31 group discussion can be in the form of a perception agreement or alternative problem solving. The focus of perceptual stimulation

group activity therapy is to help patients who experience a decline in orientation. This therapy is very effective for patients who experience perceptual disorders; hallucinations, withdrawal, reality orientation disorder, lack of initiative or ideas. Patients who take part in this therapy activity are cooperative patients, physically healthy, and able to communicate verbally.

b) The goal of TAK is perceptual stimulation

General goals: the patient has the ability to solve problems caused by exposure to the stimulus he receives.

Specific goals:

(1) The patient can perceive the stimulus that is presented to him correctly.

(2) Clients can solve problems arising from the stimulus experienced.

c) Activities in TAK are divided into four parts

(1) Perceiving real daily stimuli, namely: Perception Stimulation Group Activity Therapy (TAK) which is done is: watching television. Reading magazines/newspapers/articles and looking at pictures.

(2) Real stimulus and response experienced in life. For this TAK, the patients who follow are patients with hallucinations, and withdrawn patients who have taken TAKS, and patients with violent behavior. This activity is divided into several inseparable sessions, namely:

- Perception Stimulation Group Activity Therapy: Recognizing violence that can be done, this therapy material includes causes, signs and symptoms, violent behavior; as a result of violent behavior.

- Perception Stimulation Group Activity Therapy: preventing violent behavior through physical activity.
- Perception Stimulation Group Activity Therapy: preventing violent behavior through assertive social interaction.
- Perception Stimulation Group Activity Therapy: preventing violent behavior through medication adherence.
- Perception Stimulation Group Activity Therapy: preventing violent behavior through religious activities.

(3) Stimulus that is not real and the response experienced in life Activities are divided into several sessions that cannot be separated, namely:
Perception Stimulation Group Activity Therapy: recognize hallucinations

2) Socialization Group Activity Therapy
The general goal of socialization group activity therapy is to improve socialization skills in patients with social isolation. While the specific objectives are: typhoid and others.

e) Hallucinatory clients who are able to control their hallucinations
f) Clients with a history of anger/rage who have calmed down

c. Stages of group activity therapy (TAK) Group activity therapy consists of 4 phases, namely: 1) Pregroup Phase: This phase begins with setting therapy goals, determining the leader, number of members, member criteria, place and time of activity and the media used. The number of members in group therapy is usually 7-8 people. While the minimum number is 4 and the maximum is 10. The criteria for members participating in group activity therapy are: having been diagnosed both

medically and nursing, not too anxious, not aggressive, and not diagnosed with delusions.

2) Initial Group Phase: This phase is marked by the emergence of anxiety due to the entry of group members and new roles. This phase is divided into three phases, namely orientation, conflict, and cohesion.

a) Orientation stage

In this phase members begin to try to develop their respective social systems, the leader shows a therapy plan and agrees on a contract with members.

b) The conflict stage is a difficult period in the group process. Leaders need to facilitate the expression of feelings, both positive and negative and help the group identify the causes of conflict. As well as preventing unproductive behavior.

c) Cohesive stage: Group members feel free to open up about information and be more intimate with each other

3) Group Work Phase: In this phase, the group has become a team. The group becomes stable and realistic. At the end of this phase, group members realize increased productivity and ability accompanied by self-confidence and independence

4) Termination Phase: This phase is marked by feelings of satisfaction and group experience will be used individually in everyday life. Termination can be temporary (temporal) or final.

7. Behavior Therapy

The basic assumption of behavior therapy is that behavior arises as a result of the learning process. The basic techniques used in this type of therapy are:

a. Role models
b. Operant conditioning
c. Systematic desensitization
d. Self-control
e. Aversion therapy or reflex conditions

The role model technique strategy is to change behavior by providing examples of adaptive behavior for clients to emulate. With this technique the client will imitate and learn and imitate the behavior. This technique is usually combined with operant conditioning and desensitization techniques. Operant conditioning is also called positive reinforcement. In this technique, a therapist rewards the client for the positive behavior that has been displayed by the client. With appreciation and positive feedback, it is hoped that the client will maintain or improve it. Behavior therapy that is very suitable to be applied to phobic clients is a systematic desensitization technique, namely a technique to overcome anxiety about a stimulus or condition in a gradual way. In a relaxed state, the client is gradually introduced/exposed to a stimulus or situation that causes anxiety. The intensity of stimulus exposure increases along with the client's tolerance for the stimulus. The end result of this therapy is that the client succeeds in overcoming his fear or anxiety about the stimulus. To overcome maladaptive behavior, clients can be trained using self-control techniques. The form of the exercise is to practice changing negative words into positive ones. If this is successful, the client has the ability to control behavior so that the client's distress level decreases. Changing behavior can also be done by giving negative reinforcement. The trick is to give the experience of discomfort to change maladaptive behavior. The form of discomfort, can be in the form of removing a positive stimulus as a "punishment" for the maladaptive behavior. With this technique, 34 Mental Nursing clients learn not to repeat behavior in order to avoid the negative consequences that will be received as a result of this negative behavior.

8. Play Therapy

Play therapy is applied because there is a basic assumption that children will be able to communicate better through games than with verbal expressions. By playing, nurses can assess the level of

development, emotional status of children, diagnostic hypotheses, and carry out interventions to solve children's problems. The principles of play therapy include building a warm relationship with the child, reflecting on the child's feelings that radiate through play, believing that the child can solve the problem, and then interpreting the child's behavior. Play therapy is indicated for children who experience depression, anxiety, or as victims of abuse. Play therapy is also recommended for adult clients who experience post-traumatic stress, dissociative identity disorder and clients who experience abuse.

SUMMARY

Types of modality therapy developed in psychiatric nursing are: therapy individual, group activity therapy, family therapy, cognitive therapy, biologic therapy and group therapy and play therapy. The role of the nurse is very important in modality therapy because the nurse is the therapist who will change the patient's maladaptive behavior to be adaptive as well increase the potential of the patient. The stages of group activity therapy consist of 4 phases, namely: Pre-group phase which starting with making therapy goals, determining leaders, number of members, criteria members, place and time of activity and the media used. The next is the initial phase of the group is characterized by the emergence of anxiety due to the entry of members groups, and new roles. This phase is divided into three phases, namely orientation, conflict, and cohesive. Then the group work phase and finally the termination phase are marked by feelings of satisfaction and group experience will be used individually on everyday life. Termination can be temporary (temporal) or final.

REVIEW QUESTIONS

1) Explain the principles of perception stimulation group activity therapy

2) Explain the principles of individual therapy

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CHAPTER XVI
CONCEPT OF PSYCHOPHARMACEUTICAL

LEARNING OBJECTIVE

After studying this subject, students will be able to do the following:

1. Identify client problems in giving drugs psychopharmaceutical
2. Explain the use of psychopharmacological drugs

INTRODUCTION

Nurses have a very important role in identifying problems administration of psychopharmaceutical drugs. Identification of problems in administering psychopharmaceuticals begins from the assessment by collecting data which includes medical diagnoses, medical history, results of supporting examinations such as laboratory, type of drug used, dose, time of administration and other therapeutic programs received by patient and understand and perform various drug combinations with therapy modality. In addition, nurses must also conduct health education for clients and family about the importance of taking medication regularly and managing drug side effects and monitoring side effects of drug use. Through a comprehensive assessment, the nurse can identify the problems that are being experienced by the patient. Problem mental health experienced by patients in the program of administering psychopharmaceutical drugs grouped as follows: psychosis, depressive disorder, mania disorder, disorder anxiety, insomnia disorder, obsessive compulsive disorder and panic disorder In addition to identifying the above roles, nurses have a very important role, namely able to coordinate the various ways and work done by all team members in accordance with the goals to be achieved between the client, family and the health team so that treatment

goals can run according to the expected goals, for that nurses are required able to work in a system and high work culture.

In patients with mental disorders, the management provided includes psychopharmacological and non-psychopharmacological management. Drug management depends on the type of mental disorder experienced by the patient. The following types of drugs are used in mental health services:

1. Antipsychotics
2. Antidepressants
3. Anti-anxiety or anti-anxiety
4. Mood stabilizer

EFFECTS AND SIDE EFFECTS OF PSYCHIATRIC MEDICINES

The following table describes the effects of psychiatric drugs that are often used in the service.

Drug type	Effect
Antipsychotics	
a. First generation antipsychotics/typical antipsychotics. Examples: Haloperidol, Chlorpromazine (CPZ), Flufenazine	Overcome the positive symptoms of schizophrenia such as hallucinations, delusions, disordered behavior and thought processes
b. Second generation antipsychotics/atypical antipsychotics Examples: Risperidone, Olanzapine, Quetipepine, Aripiprazole, Clozapine	Overcome the positive symptoms of schizophrenia such as hallucinations, delusions, disordered behavior and thought processes Overcoming the negative symptoms of schizophrenia such as blunting of affect, lack of interest and initiative, social withdrawal
Antidepressants c. Tricyclic and tetracyclic antidepressants Example: Amitriptyline, Imipramine, Maprotiline d. SSRI Antidepressants (Selective Serotonin	Overcoming depressive symptoms

Drug type	Effect
Reuptake Inhibitors) Examples: Sertraline, Fluoxetine, Fluvoxamine, Citalopram e. SNRI Antidepressants (Selective Norepinephrine Reuptake Inhibitors) Examples: Venlafaxine, Mirtazapine	
Anti-anxiety or anti-anxiety ▪ Benzodiazepine class Example: Lorazepam, Alprazolam, Clobazam ▪ Another class. Example: Clonidine, hydroxyzyne	Coping with anxiety symptoms
mood stabilizers Examples: Lithium, Valproic Acid, Carbamazepine	Stabilize mood

Side effects that often appear in antipsychotic administration can be divided into side effects that are acute and chronic.

Acute side effects include:

Extrapyramidal Syndrome

a. Acute dystonia: Tonic contractions in the muscles of the neck, mouth, tongue, axillary muscles or extremities; not the same between the left and right. Can occur: Oculogyric crisis (contraction or stiffness of the eye muscles), Torticollis (contraction or stiffness of the neck muscles), Opisthotonus (contraction or stiffness of the muscles of the body)
b. Parkinsonism:
    - Parkinson’s triad: tremor (can be seen in trembling extremities, or hands like rolling pills), rigidity (stiffness), bradykinesia (slower movements, small steps)
    - Face like a mask, posture leaning forward and small steps staggering

- Excessive saliva

c. Akathisia: There is an unpleasant subjective feeling of being constantly in motion. Motor anxiety: pacing, walking in place, unable to sit/lie still, fidgeting with fingers, moving hands/arms

d. Neuroleptic Malignant Syndrome (SMN). There is generalized rigidity, accompanied by fever and autonomic instability such as tachycardia or bradycardia, hypertension or hypotension

Chronic side effects of drugs include:

- Tardive dyskinesia, namely involuntary movements of the muscles around the face, mouth, hands in the form of repetitive and aimless muscle movements.

The following can be seen a table of side effects of some antipsychotic drugs:

Medication	**Haloperidol**	**Chlorpromazine**	**Depot/long-acting fluphenazine**
Sedation	+	+++	+
Urinary hiccups	+	++	+
Orthostatic hypotension	+	+++	+
Extrapyramidal side effects*	+++	+	+++
Malignant Neuroleptic Syndrome**	Seldom	Seldom	Seldom
Tardive dyskinesia***	+	+	+
EKG changes	+	+	+
Contraindications	Decreased consciousness, bone marrow depression, pheochromocytoma, porphyria, disturbances in the basal ganglia	Decreased consciousness, bone marrow depression, pheochromocytoma	Children, decreased consciousness, parkinsonism, marked cerebral atherosclerosis

* Extrapyramidal symptoms include acute dystonic reactions, tics, tremors, muscle rigidity and cogwheels.
**Malignant Neuroleptic Syndrome is a rare but potentially life-threatening disorder. Characterized by muscle rigidity, increased body temperature and blood pressure.
*** Tardive dyskinesia is a long-term side effect of antipsychotic medication which is characterized by involuntary muscle movements, especially of the face, hands and chest.

Antidepressant side effects
Older Generation Antidepressants (Tricyclic and Tetracyclic):
Adverse side effect profile; anticholinergics, orthostatic hypotension, impaired cardiac conduction.

New Generation Antidepressants (SNRI & SSRI):
The side effect profile is better, the most common complaints are headaches, gastrointestinal disturbances.
Drug interactions are particularly related to metabolism in the liver; the new generation is better than tricyclic

Anticholinergic side effects
- Impaired sensorium & cognitive function
- Blurred vision
- Retention of urine/alvi
- Dry mouth

Cardiovascular side effects
- Orthostatic hypotension→cerebral hypoxia
- Quinidine like effect→severe arrhythmia

Other side effects
a. Gastrointestinal disorders (nausea-vomiting-diarrhea)
b. Sedation

c. Psychomotor agitation
d. Extrapyramidal symptoms
e. Hyper serotonergic syndrome

Side effects of anti-anxiety/anti-anxiety

Anti-anxiety drugs are generally given for a short period of time, about 2 weeks and then the dose is reduced periodically to stop. Long-term use of benzodiazepine drugs can cause dependence and if stopped suddenly can cause symptoms to recur.

Mood stabilizer side effects

It is necessary to think about the possibility of a severe drug allergic reaction to the use of the mood stabilizer carbamazepine. Severe reactions that may occur are Steven Johnson Syndrome with rash manifestations all over the body.

Other side effects that may occur in administering the mood stabilizer valproate acid include gastro intestinal side effects (nausea, discomfort in the digestive tract), weight gain and in female patients it is necessary to observe the possibility of polycystic ovaries.

Plan for patients who experience problems due to side effects of antipsychotics and other psychiatric drugs

In patients who are given psycho-pharmaceutical drugs, it is necessary to provide health education to the family about the symptoms of drug side effects that may be experienced by family members. If there is a suspicion of a drug side effect, immediately ask the patient to consult a doctor for an assessment of the severity of the side effects. In severe side effects, the drug often has to be stopped and the type of drug changed, then treatment is given to deal with the side effect of the drug. In mild drug side effects, the dose of the drug can be reduced and management given to treat side effects.

Drugs that can be used to treat the side effects of antipsychotic drugs:

Medicine name	**To deal with side effects**
Trihexyphenidyl (oral)	Extrapyramidal syndrome
Dyphenhydramine (IM injection)	Extrapyramidal syndrome, especially acute dystonia
Propranolol (oral)	Extrapyramidal syndrome, especially akathisia
Clonazepam (oral)	Extrapyramidal syndrome
Atropine sulfate (IM injection)	Extrapyramidal syndrome, especially acute dystonia

In patients with Neuroleptic Malignant Syndrome (SMN)

a. Rule out meningitis or encephalitis.

b. Stop antipsychotic medication. The effects of antipsychotic drugs will last for some time day. Depot antipsychotic drugs can last for several weeks.

c. Intensive supportive action needs to be done.
   - Adequate hydration, monitor urine output
   - High fever should be given antipyretics and compresses
   - Arrhythmias must be treated when they occur
   - Hypotension may require volume expansion and pressor drugs.
   - The patient is placed in a position that prevents nerve compression injury, aspiration or decubitus ulcers.
   - Refer immediately if the patient's condition allows.

THE ROLE OF THE NURSE IN THE ADMINISTRATION OF PSYCHOPHARMACEUTICAL DRUG

Because you have been able to understand well the problems experienced and strategies for administering psychopharmaceutical drugs to clients with mental disorders, then the following discussion

is the role of the nurse in administering psychopharmaceuticals. As for these steps

will be described as follows. Happy learning, I hope you can learn it well good.

1. Assessment.
   A comprehensive review will provide a true picture about the conditions and problems faced by clients, so they can immediately determine collaborative steps in the administration of psychopharmaceuticals.
2. Coordination of modality therapy.
   The coordinator is one of the roles of a person nurse. The nurse must be able to coordinate the various therapeutic modalities and therapy program so that the client understands the benefits of therapy and ensures that the program therapy is acceptable to the client.
3. Providing psychopharmacological therapy. Nurses have a very big role to play ensure that the psychopharmacological therapy program is given correctly. right client, right drug, right dose, right way of administration, and right time
4. Monitoring drug effects. Nurses must closely monitor any drug effects given to the client, both the benefits of the drug and the side effects experienced by clients.
5. Client educator. As an educator or nurse educator must provide health education for clients and families so that clients and families understand and want to participate actively in carrying out the therapy program has been set for the client.
6. Drug maintenance program. Aims to provide provision of health knowledge to clients about the importance of continuing treatment after being treated.
7. Participation in interdisciplinary clinical research on drug trials.
   The nurse participates actively as part of the client's treatment research team

D. EVALUATION OF THE ADMINISTRATION OF PSYCHOPHARMACEUTICAL DRUG

Evaluation of drug administration must continue to be carried out by nurses to assess drug effectiveness, drug interactions and side effects of drug administration. Here's an evaluation
which must be done

1. Giving benzodiazepines, nonbenzodiazepines, tricyclic antidepressants, MAOIs, lithium, antipsychotic. Benzodiazepines are generally highly addictive unless discontinuation of administration is carried out by gradual tapering will not cause addiction. The use of this drug when mixed (used together) with barbiturate drugs or alcohol will cause addictive effects. Monitoring side effects such as sedation, ataxia, sensitivity to stimuli, impaired memory.
2. The use of nonbenzodiazepine drugs has many disadvantages, such as occurring tolerance to the antianxiety effects of barbiturates, the more addictive, causes a reaction serious and even lethal effects on withdrawal symptoms, dangerous if the drug is administered in large doses can cause depression of the central nervous system, as well cause dangerous side effects.
3. Tricyclic antidepressants can be lethal if given in different doses because the effect of the drug becomes longer (3-4 weeks), this drug is relatively safe because has no side effects if used for a long time if given in the right dose. Persistent side effects can be minimized by slightly lower the dose, this drug does not cause euphoria, can be given one times a day. Does not cause addiction but intolerance to vitamin B6.
4. Use of lithium can cause lithium toxicity which can be life-threatening. Nurses should monitor lithium levels in the blood. If lithium administration is not to produce the expected effect, this drug can be combined with anti-inflammatory drugs another depressant. The need for health education for clients

regarding how to monitor lithium level.

5. The use of anti-psychotics must consider the following guidelines that anti-psychotic doses vary greatly for each individual. Dosage is given once a day, the therapeutic effect will be obtained after 2-3 days but can be up to 2 weeks. For long-term treatment, weekly clozapine should be considered to monitor for a decrease in the white blood cell count.

SUMMARY

Nurses have an important role in the psychopharmacological therapy program, for that nurses must have sufficient knowledge about the problem being faced by clients. Results of identification of mental health problems experienced by clients related to the program of administering psychopharmaceutical drugs can be grouped as following: psychosis, depressive disorder, mania disorder, anxiety disorder, disorder insomnia, obsessive compulsive disorder and panic disorder. How to use psychopharmaceutical drugs. Nurses must understand the inner principles administration of psycho-pharmaceutical drugs which include types, benefits, doses, how the drug works in the body, side effects, route of administration, contraindications. The role of nurses in administering psychopharmaceutical drugs. The role of the nurse in giving psychopharmaceutical drugs include client assessment, modality therapy coordination, administration psychopharmacological tools, drug effect monitoring, client education, maintenance programs drugs, and participation in interdisciplinary clinical research on drug trials. Evaluation of psycho-pharmaceutical administration. Evaluation of psychopharmaceutical administration aimed at alerting nurses to the use of psychopharmaceutical drugs. Nurses should be aware that some problems may arise with regard to use of psychopharmacological drugs.

REVIEW QUESTIONS

1) Explain how to use psychopharmaceutical drugs?
2) Explain the role of the nurse in administering psychopharmaceutical drugs?
3) Explain the principles of evaluation in administering psychopharmaceutical drugs?

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CHAPTER XVII
THE CONCEPT OF RECOVERY IN PSYCHIATRIC NURSING SERVICES

LEARNING OBJECTIVE

1. Organizing the definition of recovery in psychiatric nursing
2. Integrating the recovery in psychiatric nursing
3. Comparing about mental disorders rehabilitation and traditional medical treatment models

INTRODUCTION

Rehabilitation is an attempt to guide the patient to recovery. Patients are trained to live independently and participate in society though have a disability due to a chronic disease it has. Based on the principle of rehabilitation recovery of mental patients is not interpreted as the disappearance of symptoms and signs of lifelong mental disorder his life. Mental patient said recover if he can work, study and participate as optimally as possible in environment. Rehabilitation is more emphasis on restoration of one's function of life so they can live independently and productive.

RECOVERY

People with severe mental illness who receive appropriate and individualized support can recover from their illness and lead productively fulfilling lives. Recovery is a journey process of achieving healing and transformation that enables a person with a mental disorder to live meaningfully in the community he chooses to achieve the competencies he has. Self-strength is the foundation of a self-centered and self-motivated recovery support system. Having feelings plays an important role in individual recovery (Stuart, 2010).

Individuals receive recovery support through activities identified as rehabilitation, which is the process of helping a person return to the highest attainable level of functioning. Rehabilitation for mental disorders is a combination of social, educational, occupational, behavioral and cognitive services aimed at long-term recovery and maximizing self-sufficiency. A number of evidence-based practices that support and enhance recovery include: community-acceptive treatment, work support, illness management and recovery, integrated treatment to assist recurrent mental disorders and substance abuse, family psychoeducation, treatment management and permanent housing support.

COMPONENT RECOVERY

1. Self-power
2. Centered on individualization and people
3. Empowerment
4. Holistic
5. Nonlinear
6. Basic strength
7. Friend/Peer support
8. Award
9. Responsibility
10. Hope

COMPARISON OF MENTAL DISORDERS REHABILITATION AND TRADITIONAL MEDICAL TREATMENT MODELS

Care Aspect	Mental Disorder Rehabilitation	Traditional Medical Treatment
Focus	Focus on well-being and health, not on symptoms	Focus on disease and symptoms
Base	Based on individual ability and functional behavior	Based on individual disability and intrapsychic functioning

Medical relationship setting	Nursing behavior is in a natural order Relationships between adults Medication appropriately and tolerate some of the symptoms of the disease	Actions within the institutional setting Expert relationship with clients Medication until symptoms are controlled
Decision-making emphasis	Case management through collaboration with clients Emphasis on strength, self-help and interdependence	The doctor makes a decision and prescribes a treatment regimen Emphasis on dependability and compliance

POTENTIAL SKILLS REQUIRED IN RECOVERY SUPPORT

Physique	Emotion	Intellectual
Life skills Personal hygiene Physical fitness Use of public transportation Cooking Shopping Cleaning the house Sports participation Use of recreational facilities	Human relations Self-control Selective award Stigma reduction Problem solving Communication skills	Financial management Using community resources Goal setting Problem development
Learning skills Be calm Give attention Stay seated Observe Punctuality	Make conversation Asking question Answer spontaneously Follow directions Ask for directions Listen	Read Write Arithmetic Study ability Hobby activity Type
Work skills Punctuality Use of work tools Work strength	Job interview Make job decisions Human relationship	Job qualifications Find a job Special job

Physique	Emotion	Intellectual
Job transportation Special job assignments	Self-control Keep job Special job assignments	assignments

DISEASE MANAGEMENT AND RECOVERY

1. Psychoeducation: an approach that supports the recovery process by teaching clients and families about mental disorders and coping skills that will help them to be successful in social life. It is defined as the process of conveying disease management information in a way that individuals can understand and implement.
2. Formation of behavior for treatment: developing strategies with clients to integrate medication regimens into daily routines and simplify treatment schedules.
3. Relapse prevention training: most people with a severe mental illness can learn to recognize the signs and symptoms of the onset of a relapse. This can help them to seek action as early as possible so that the disease episodes will be milder and can be treated in the community.
4. Coping skills training: teaching clients techniques for recognizing persistent symptoms of mental disorders. For example, someone who has auditory hallucinations can be trained to listen to music using headphones, thereby reducing distraction from sounds (distraction).

ELEMENTS OF THE PSYCOEDUCATIONAL PLAN

1. Signs and symptoms
2. The nature of the disease
3. Possible etiology
4. Diagnostic examination and action
5. Indication of lifestyle changes

6. Treatment options
7. Expected treatment results
8. Medication side effects
9. therapeutic strategy
10. Adaptive coping response
11. Potential compliance issues
12. Early signs of relapse
13. Balancing needs and self-care

ACCESSING COMMUNITY SUPPORT

The community-based care model includes case management and assertive community treatment (ACT). In Indonesia, community mental health nursing has been developed in each health center. Mental disorder rehabilitation programs (psychosocial rehabilitation) were developed in response to outpatient mental illness clients who lack the skills and resources needed to live independently.

COMMUNITY SUPPORT SYSTEM COMPONENTS

1. Client
2. Case management
3. Mental health treatment
4. Client identification
5. Crisis response service
6. Dental health and care
7. Housing area
8. Protection and advocacy
9. Financial support and rights
10. Friend/peer support
11. Family and community support
12. Rehabilitation services

PRINCIPLE OF PERSONAL ASSISTANCE IN THE COMMUNITY

1. A person completely recovers from even the most severe

types of mental disorders

2. Trust is the cornerstone of recovery
3. Control and coercion are emphasized when there is a lack of trust and impaired recovery
4. One must be able to follow their own dream, not someone else's dream in order to recover
5. Self-determination is very important for recovery
6. Understanding that mental illness is a label for severe emotional stress that interferes with one's role in society helps in recovery
7. People who believe that people with mental disorders can help themselves to recover
8. There is always meaning, even in periods of the greatest emotional stress and understanding that meaning helps in recovery
9. People can and do crave to connect emotionally especially when they are experiencing great emotional stress
10. Feeling emotionally safe in a relationship is very important for expressing feelings
11. Everything that's been learned about the importance of human connection also applies to people labeled as mentally disorder

SUMMARY

Rehabilitation approach emphasize development skills and support needed for success in life, study and work in society. This approach creates collaborative partnership between clients with mental disorders, family, friends and care provider in nursing services. Rehabilitation models will contain beliefs and values certain. Opportunity to be able to work is the generative power in humans, work can increase self-esteem and reduce symptoms as well as everyone need a chance to live together in a social environment. The rehabilitation approach contains important values

in life, including: individual hope and optimism for grow, learn and make changes in his life, the promotion of choice, self-determination, responsibility individual and affection.

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CHAPTER XVIII
MANAGEMENT CONCEPTS OF COMMUNITY MENTAL HEALTH NURSING SERVICES

LEARNING OBJECTIVE

1. Organizing the definition community mental health nursing
2. Integrating goals of community mental health nursing
3. Explain about program the community mental health nursing

INTRODUCTION

Community mental health nursing is a comprehensive, holistic and plenary nursing service; focuses on people who are mentally healthy, vulnerable to stress & in the stage of recovery and prevention of relapse. Services are provided continuously (continuity of care) throughout the span of human life. Comprehensive nursing services are focused on: primary prevention for community members who are mentally healthy, secondary prevention for community members who experience psychosocial problems and mental disorders and tertiary prevention in patients with mental disorders with the recovery process. Services are provided continuously (continuity of care) from health to illness and vice versa, both at home and in hospitals (in various places) and from the womb to the elderly.

THE CONCEPT OF COMMUNITY MENTAL HEALTH NURSING (CMHN)

1. Definition of Community Mental Health Nursing (CMHN)

Community mental health nursing is a comprehensive, holistic and plenary nursing service that focuses on people who are mentally healthy, vulnerable to stress (risk of mental disorders) and

in the stages of recovery and prevention of relapse (mental disorders). Comprehensive nursing services are services that are focused on primary prevention for mentally healthy community members, secondary prevention for community members experiencing psychosocial problems (risk of mental disorders) and tertiary prevention for mentally ill patients with a recovery process (Keliat et al., 2012).

Holistic nursing services are comprehensive services to all aspects of human life, namely bio-psycho-social-cultural and spiritual aspects, (1) The (bio-physical) aspect is associated with physical health problems such as loss of organs experienced by community members due to disasters that require services in the context of their adaptation to their physical conditions. Likewise with other physical illnesses, both acute, chronic and terminal which have an impact on mental health, (2) The psychological aspect is associated with various psychological problems experienced by the community such as fear, trauma, anxiety and more severe conditions that require services so that they can adapt to this situation, (3) social aspects associated with loss of husband/wife/children, close family, loss of job, place of residence, and assets that require services from various related sectors so that they are able to maintain a satisfying social life., (4) Cultural aspects are associated with a culture of mutual help and kinship which can be used as a social support system in overcoming various problems found, (5) Aspects spirituality is associated with strong religious values that can be empowered as community potential in overcoming various conflicts and health problems that occur (Keliat et al., 2012). Complete nursing services are services at all levels of service, namely from specialist mental health services, integrative mental health services and community-based mental health services. Empowerment of all the potential and existing resources in the community is sought to create a society that is independent in maintaining its health. Plenary nursing services will be described in

more depth in the community organizing module. Nursing services are provided continuously (Continuity of care) from healthy or sick conditions and vice versa, both at home and in the hospital, (wherever people are), from in the womb to the elderly (Keliat et al., 2012).

5. Goals of Community Mental Health Nursing (CMHN)

The goal of Community Mental Health Nursing (CMHN) is to provide services, consultation and education, or provide information about mental health principles to other community agents. Another goal is to reduce the risk of mental disorders and increase community acceptance of mental health practices through education (Yosep & Titin, 2014).

6. Community Mental Health Nursing (CMHN) Program

Marthoenis et al. (2016). the Community Mental Health Nursing (CMHN) program implemented in Aceh is the Mental Health Alert Village, activities carried out include detecting cases of mental disorders in their environment, visiting patients' homes, and ensuring that patients take medication. Mental Health Alert Village is a form of community mental health nursing service that has a vision of "Improving community mental health, preventing mental health problems in the community, and optimizing the living abilities of mental patients in the community according to their abilities by empowering families and communities. An example of the vision of a Mental Health Alert Village is "Healthy Society Through Mental Health Alert Village" (Keliat et al., 2010).

The main focus of the Community Mental Health Nursing (CMHN) program in Desa Siaga Sehat Jiwa are:

(a) CMHN nurse activities: mental health education for healthy community groups (families with babies, children, pre-school age, school age, youth, young adults, adults, and the elderly), mental health education for groups of patients who are at risk of psychosocial problems (patients with violent behavior, social isolation, low self-esteem, hallucinations, lack of self-care), TAK

group activity therapy activities for patients with mental disorders independently, rehabilitation activities for independent mental patients, nursing care for families of mental patients.

(b) activities of mental health cadres: detecting families in the Mental Health Alert Village, the risk of psychosocial problems and mental disorders, Community Mental Health Nursing (CMHN) interventions include:

(1) Primary: interventions carried out by Health Promotion & Mental Health Prevention, mental health promotion, prevention and prevention of mental disorders, targeting community members who are not experiencing disorders according to the age group of children, adolescents, adults, and parents.

(2) Secondary: interventions carried out in the form of early detection of psychosocial problems and mental disorders in the community, coaching community members who are at risk or exhibit psychosocial problems and mental disorders.

(3). Tertiary: interventions in the form of increasing function, socialization and prevention of relapse during mental disorders, targeting community members who experience mental disorders in the rehabilitation process (Yosep & Titin, 2014).

7. Community Psychiatric Nursing Services

Comprehensive mental nursing services are mental nursing services provided to post-disaster and conflict communities, with very diverse community conditions in the health-illness range that require nursing services at the primary, secondary and tertiary prevention levels. Comprehensive mental health nursing services include 3 levels of prevention, namely primary, secondary and tertiary prevention (Keliat et al., 2012).

b. Primary Prevention Primary care settings can be the most important point of contact between clients with mental health problems and the health care system. Most people will seek help for their mental health problems through

primary care providers. Mental health services in primary care settings can also reach people who do not receive mental health measures. This provides expertise regarding the diagnosis and treatment of problems not seen in the general medical setting, which results in increased knowledge and skills in the early detection and treatment of mental health problems in the medical community (Stuart et al., 2016). The focus of mental nursing services is on improving health and preventing mental disorders.

The aim of the service is to prevent mental disorders, maintain and improve mental health. The service target is community members who have not experienced mental disorders according to age groups, namely children, adolescents, adults and the elderly. Activities in primary prevention are health education programs, development stimulation programs, mental health outreach programs, stress management, preparation for becoming parents (Keliat et al., 2012). The activities carried out are:

1). Providing health education to parents, among other things, such as parenting education, education about child development according to age, monitoring and stimulating development, socializing children with the environment.

2). Health education addresses stress such as job stress, marital stress, school stress and post-disaster stress.

3). Social support programs are given to orphans, individuals who have lost spouses, lost jobs, lost homes/dwellings, all of which may occur as a result of a disaster. Activities carried out Providing information on how to deal with loss, mobilizing community support such as becoming foster parents for orphans, training skills according to their respective expertise to get a job, getting support from the government and NGOs to get a place to live.

4). Drug abuse prevention program. Drug abuse is often used as coping to overcome the problem. Activities that can be carried out are health education, practicing positive coping to deal with stress, assertive training, namely expressing desires and feelings without hurting others, affirmation exercises by strengthening the positive aspects that are in a person. 5). Suicide prevention program. Suicide is one way of solving problems by individuals who experience hopelessness. Therefore, it is necessary to carry out programs: Providing information to increase public awareness about the signs of suicide, providing a safe environment to prevent suicide, practicing adaptive coping skills (Keliat et al., 2012).

c. Secondary Prevention

Secondary prevention is directed at those who have been exposed to certain diseases so that their condition does not worsen (Setiadarma, 2002). According to (Keliat et al., 2012), the focus of nursing services on secondary prevention is early detection and immediate treatment of psychosocial problems and mental disorders.

The aim of the service is to reduce the incidence of mental disorders. Service targets are members of the community who are at risk or show signs of psychosocial problems and mental disorders. Activities in secondary prevention are:

1. Finding cases as early as possible by obtaining information from various sources such as the community, other health teams, and direct discovery.

2. Screening cases by taking the following steps:

a. Conduct a two-minute assessment to obtain focus data on all patients who seek treatment at the public health center with physical complaints (the format is attached to the recording and reporting module).

b. If signs related to anxiety and depression are found, then

continue the assessment using a mental health nursing assessment.

c. Announcing to the public about early symptoms of mental disorders (in public places). d. Provide fast treatment of new cases found in accordance with standard treatment program delegation (in collaboration with doctors) and monitor side effects of drug administration, symptoms, and patient adherence to taking medication.

e. Collaborate with community nurses in administering other medicines needed by patients to treat physical problems they are experiencing (if there are physical problems that require treatment).

f. Involve the family in drug administration, teach the family to report immediately to the nurse if any unusual signs are found, and inform the follow-up schedule.

g. Handle suicide cases by placing the patient in a safe place, carrying out strict supervision, strengthening coping, and make referrals if life threatening. Placing the patient in a safe place before being referred by creating a calm environment, and minimal stimulus.

h. Perform modality therapy, namely various nursing therapies to help patient recovery such as group activity therapy, family therapy, and environmental therapy.

i. Facilitating self-help groups (patient groups, family groups, or community groups) in the form of group activities that discuss problems related to mental health and how to solve them.

j. Providing a hotline service for crisis intervention, namely 24-hour telephone service in the form of counseling services.

k. Perform follow-up (follow-up) and referral of cases. Placing the patient in a safe place before being referred by creating a calm environment, and minimal stimulus.

d. Tertiary Prevention (Setiadarma, 2002) put forward that tertiary prevention applies to those who are affected by a disease disorder that is severe enough so that their life is not threatened. According to (Keliat et al., 2012) Tertiary Prevention is a nursing service that focuses on nursing services on improving function and outreach and prevention of recurrence in patients with mental disorders. The goal of service is to reduce disability or disability due to mental disorders. The service target is community members who experience mental disorders at the recovery stage. Activities in tertiary prevention include:

1. Social support programs by mobilizing community resources such as educational resources, community support (neighbors, close friends, community leaders), and the closest services that are accessible to the community. Some of the activities carried out are:

   (a) Health education about the behavior and attitudes of the community towards the acceptance of patients with mental disorders.

   (b) An explanation of the importance of using health services in the treatment of patients who experience relapse.

2. Rehabilitation programs to empower patients and families to become independent focus on the strengths and abilities of patients and families by: (a) Improving coping skills, namely learning to express and solve problems in the right way, (b) Developing a support system by empowering families and communities, (c) Providing capacity and potential training that needs to be developed by patients, families and communities so that patients can be productive again, (c) Helping patients and families plan and make decisions for themselves.

3. Outreach program: (a) Creating a meeting place for

socialization, (b) Developing life skills (ADL daily living activities), managing the household, developing hobbies, (c) Recreation programs such as watching movies together, walking leisurely, going to recreational areas, (d) Social and religious activities, (joint social gathering, recitation, traditional activities).

4. Programs to prevent stigma. Stigma is a wrong assumption from society about mental disorders. Therefore, it is necessary to provide a program to prevent stigma to avoid isolation and discrimination against mental patients. Some of the activities carried out are: (a) Providing health education to the public about mental health and mental disorders, as well as about attitudes and actions to respect patients with mental disorders,

SUMMARY

Community Mental Health Nursing is a comprehensive, holistic and plenary nursing service that focuses on people who are mentally healthy, vulnerable to stress (risk of mental disorders) and in the stages of recovery and prevention of relapse (mental disorders). Mental disorders are behavioral or psychological patterns shown by individuals that cause distress, dysfunction, and reduce quality of life. People with mental disorders or mental disorders have symptoms and behaviors that can interfere with their ability to work, provide affection needs, interfere with access to physical health care, education, household, transportation, decision making, and use of leisure time. In patients with mental disorders, basic abilities are often disrupted, such as Activities of Daily Living (ADL). With this statement it can be concluded that people who experience mental disorders in carrying out activities in their life experience limitations or can be said to need assistance (not independent) in carrying out any activities or Activities of Daily Living (ADL) in their lives. Mental health problems in the community

require approaches and strategies involving the community supervised by health workers. Comprehensive community psychiatric nursing services cover 3 levels of prevention namely primary, secondary and tertiary prevention.

REVIEW QUESTIONS

1. A man, 24 years old, a nurse at a health center, a mental programmer who manages the Mental Health Alert Village through a community mental health nursing program. Based on the results of early detection in the village area, data on the healthy group, risk and mental disorders were obtained. The nurse then plans community mental health nursing service activities that focus on primary prevention. What types of activities can be carried out by nurses in accordance with these services?
   a. Developmental stimulation program
   b. Collaboration with other healthcare teams
   c. Prompt treatment of new cases
   d. Perform modality therapy in the community
   e. Involve the active role of the family in caring for clients at home
2. Community mental health nursing service activities that focus on secondary prevention are carried out through activities?
   a. Rehabilitation program
   b. Suicide prevention program
   c. Drug abuse prevention program
   d. Case finding program through early detection
   e. Programs prevent and eliminate stigma
3. Community mental health nursing service activities that focus on tertiary prevention are carried out through activities?
   a. Suicide prevention program
   b. Drug abuse prevention program
   c. Case finding program through early detection

d. Programs prevent and eliminate stigma
e. The program carries out follow-up care and case referrals

4. A woman, 34 years old, serves at the public health center and is responsible for managing the community mental health program. Nurses make home visits every two weeks and provide direct nursing care to clients with mental disorders. The role of the nurse in developing the mental health of the community as?
   a. Practitioner
   b. Researcher
   c. Educator
   d. Consultant
   e. Coordinator
8. Losing a loved one and experiencing a job breakup are aspects of holistic nursing services that focus on?
   a. Physique
   b. Social
   c. Culture
   d. Spiritual
   e. Psychological

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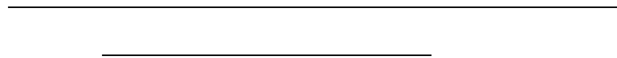

Ns. Sutejo, S.Kep., M.Kep., Sp.Kep.J. studied Nursing Specialist Psychiatric Nursing at Faculty of Nursing Universitas Indonesia in 2010, Master in Nursing at Faculty of Nursing Universitas Indonesia in 2009, Nurse at Nursing Science Study Program Faculty of Medicine Universitas Diponegoro in 2007, Bachelor of Nursing at Nursing Science Study Program Faculty of Medicine Universitas Diponegoro in 2006, and Diploma III of Nursing in Nursing Study Program Cirebon Health Polytechnic Ministry of Health Tasikmalaya in 2003.

The writer's professional history includes the Person in Charge of Training at the Health Polytechnic Ministry of Health Yogyakarta 2022–2026 and the Academic Coordinator of the Diploma III of Nursing Study Program at the Health Polytechnic Ministry of Health Yogyakarta 2019–2022. The author's organizational history is as Chair of the Regional Board of the Indonesian Mental Health Nurses Association DIY 2015–2022, Quality Assurance of Indonesian Nursing Vocational Education Institute Association Regional XIII DIY 2019–2023 and Secretary of the Honorary Council of Nursing Ethics Indonesian National Nurses Association DIY 2022–2026.

Author has participated in several trainings including The International Mental Health Training Center Taiwan (IMHTCT) Training Program 2020 Online Course, Ministry of Health and Welfare & Kaohsiung Kai Suan Psychiatric Hospital; RPI Institute Systematic Literature Review Article Writing Training, 2021; Extensive Class Majoring in Short English Training, ELFAST Pare Kediri, 2022; Integrated Training of Trainers (TOT) Indonesian National Nurses Association DIY, 2022; and Prometric Test Training, Institute of Health Science Budi Luhur Cimahi, West Java, in 2022.

Penerbit Deepublish (CV BUDI UTAMA)
Jl. Kaliurang Km 9,3 Yogyakarta 55581
Telp/Fax : (0274) 4533427
Anggota IKAPI (076/DIY/2012)
cs@deepublish.co.id
Penerbit Deepublish
@penerbitbuku_deepublish
www.penerbitdeepublish.com

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