521487-216

TECHNICAL MANUAL
No. 8-243

HEADQUARTERS,
DEPARTMENT OF THE ARMY
WASHINGTON 25, D.C., *23 August 1962*

NEUROPSYCHIATRIC SPECIALIST

			Paragraph	Page
CHAPTER	1.	GENERAL	1–5	3
	2.	PERSONALITY GROWTH AND DEVELOPMENT.		
Section	I.	Introduction	6, 7	6
	II.	Basic factors underlying personality development.	8–12	7
	III.	Developmental tasks	13–19	8
	IV.	Dynamics of personality	20–24	10
	V.	Ego defense mechanisms	25–41	11
	VI.	The mature personality	42, 43	15
CHAPTER	3.	MILITARY PSYCHIATRIC SERVICES	44–48	17
	4.	THE ROLE OF THE PSYCHIATRIC SPECIALIST.		
Section	I.	General	49, 50	23
	II.	Establishing therapeutic relationships	51–54	24
	III.	Understanding the patient's behavior	55, 56	29
	IV.	Communicating with the patient	57–60	31
	V.	Using psychiatric team relations	61–66	34
	VI.	Observing and reporting	67–69	37
CHAPTER	5.	THERAPEUTIC HOSPITAL ENVIRONMENT.		
Section	I.	General	70, 71	40
	II.	Basic aspects of a therapeutic environment	72, 73	41
	III.	Therapeutic activities	74–76	44
	IV.	Physical care	77, 78	45
	V.	Proper nutrition	79–82	48
	VI.	Control of hazards	83, 84	51
	VII.	Prevention of suicide	85–89	54
	VIII.	Prevention of escape	90, 91	58
	IX.	Prevention and management of assaultive behavior.	92, 93	60

* This manual supersedes TM 8-243, 21 June 1955.

		Paragraph	Page
CHAPTER 6.	PSYCHIATRIC DISORDERS	94, 95	63
7.	NURSING CARE OF PSYCHIATRIC PATIENTS.		
Section I.	New patient	96–100	66
II.	Anxiety as the motivator of behavior	101–106	70
III.	Patient who controls anxiety with physical symptoms.	107–109	72
IV.	Patient who controls anxiety with ritualistic behavior.	110–112	73
V.	Patient who controls anxiety by projection	113–115	75
VI.	Patient who is withdrawn	116–118	77
VII.	Patient who is overactive	119–121	79
VIII.	Patient whose behavior is antisocial	122–124	81
IX.	Patient who depends upon an emotional crutch	125–130	83
X.	Patient with an organic brain disorder	131–135	87
XI.	Patient with epilepsy	136–141	90
XII.	Patient who is to be discharged	142–146	94
CHAPTER 8.	DIAGNOSTIC AND THERAPEUTIC PROCEDURES.		
Section I.	Psychiatric examination	147, 148	100
II.	Lumbar puncture (spinal tap)	149–154	100
III.	Electroencephalogram	155–158	103
IV.	Chemotherapy	159–162	104
V.	Electroconvulsive therapy	163–167	108
VI.	Insulin therapy	168–170	112
VII.	Psychotherapy	171–174	113
CHAPTER 9.	COMBAT EXHAUSTION		
Section I.	Introduction	175–177	116
II.	Combat stresses	178–180	117
III.	Reactions to stresses	181, 182	119
IV.	Defense against anxiety	183, 184	120
V.	Recognizing combat exhaustion	185, 186	122
VI.	Treatment of combat exhaustion	187–189	124
VII.	Responsibilities of the specialist	190–192	126
APPENDIX I.	REFERENCES		128
II.	CLASSIFICATION OF NEUROPSYCHIATRIC DISORDERS.		132
GLOSSARY			139
INDEX			152

CHAPTER 1
GENERAL

1. Purpose and Scope

a. This manual is to serve as a reference book and guide for neuropsychiatric specialists who are performing psychiatric nursing duties and for enlisted personnel who are learning to perform such duties. It may serve to acquaint all other members of the psychiatric team and command with the role of the neuropsychiatric specialist. It may be an aid in attaining greater uniformity in concepts, principles, and procedures used by neuropsychiatric specialists throughout the Army Medical Service.

b. Fundamental concepts, basic principles, and general procedures to be used by the neuropsychiatric specialist in Army medical installations in the zone of interior and in a theater of operations are explained in this manual. The major subjects discussed are personality development and patterns of adjustment, psychiatric illnesses, and nursing care of psychiatric patients.

c. Users of this manual are encouraged to submit recommended changes or comments to improve the manual. Comments should be keyed to the specific page, paragraph, and line of the text in which the change is recommended. Reasons should be provided for each comment to insure understanding and complete evaluation. Comments should be forwarded direct to the Office of The Surgeon General, ATTN; MEDPT–TD, Department of the Army, Washington 25, D.C.

2. Applicability to Types of Warfare

The material presented herein is applicable without modification to both nuclear and nonnuclear warfare.

3. Basic Concepts Underlying Human Behavior

The success which the neuropsychiatric specialist achieves in his work and the satisfaction that he receives from it depend upon his personal attitudes and beliefs about mental illness and mentally ill patients. He must accept psychiatric patients as people with human dignity and recognize their behavior as exaggerations of normal behavior. The attitudes and beliefs which enable him to

do this are acquired by obtaining an understanding of psychiatric patients. The following basic concepts will help to guide his thinking as he strives to develop this understanding.

a. All People Are Worthwhile. Each individual has strengths as well as weaknesses, past achievements as well as failures, future dreams, and expectations. Each person is recognized for his intrinsic worth and valued as a human being regardless of his behavior.

b. Every Person Is Different. Although people are alike in many respects, they are different in many others. Differences are manifested in physical appearance as well as in the importance attached to all aspects of living in a culture. Each person's motivations and goals are different. They do not gain the same satisfaction from personal achievements. Each person has his own particular set of standards, which he constantly changes and readjusts in the process of living. A person's behavior is the result of his total life experiences. Every person is accepted as an individual without prejudgment of his behavior.

c. All Behavior Is Purposive. People do not behave randomly or accidentally. A person's behavior is the product of both conscious and unconscious motivational forces. In his behavior he is trying to solve problems of living. Behavior is viewed objectively with an attempt to understand why the person behaves as he does.

d. People Have the Capacity to Change. No person is the helpless victim of forces and pressures which existed long ago. People have the innate capacity to become different as the world about them alters and changes. Without this belief, treatment of psychiatric patients would be purposeless. People are approached with the belief that a hostile person can become friendly, an anxious person can be put at ease, and a depressed person can be cheered.

e. Every Person Has a Natural Tendency to Grow Toward Maturity. No person remains at a standstill; he either grows or regresses. He will follow the natural tendency toward growth unless he is in some way prevented. Even when a person is confronted with tragedy, illness, or injury, the natural tendency is to grow toward maturity. Psychiatric patients are provided an environment which encourages them to follow this tendency.

f. People Have the Right to Participate in Decisions Affecting Their Welfare. In accordnance with democratic philosophy, all people have the right to participate in decisions which affect their welfare. Participation is essential to growth and development. Although an emotional disturbance or illness may temporarily impair a person's ability to make rational decisions about what is best for him, he is encouraged to express himself and participate as much as he is able.

4. Mental Health

There is no single, completely acceptable, all-inclusive definition of mental health. Mental health defies an accurate description because it varies with time, place, and culture and with expectation of the social group. It is much more than the absence of mental illness. It is not just being free of problems because no person is immune to tragedy, illness, and injury which can wreck life plans. From a broad point of view, a mentally healthy person feels comfortable about himself and right about other people. He stands on his own two feet and does not make undue demands or impositions on others. Characteristically, he faces his problems and finds ways to solve them.

5. Mental Illness

Mental illness is almost as difficult to define as mental health. No single definition is acceptable to everyone. Mental illness cannot be defined by the nature of behavior alone because what is considered abnormal in one culture is normal in another. Each person's behavior must be viewed in relation to the social norms and values of his community. Abnormal behavior is not the result of any one factor but is the sum of a person's life experiences and reactions to them. Generally, a person is considered mentally ill when his characteristic patterns of behavior cause sufficient difficulty in living to disrupt his work, relations with people, response to social norms, and sense of his own value.

CHAPTER 2

PERSONALITY GROWTH AND DEVELOPMENT

Section I. INTRODUCTION

6. General

In order for the specialist to acquire an understanding of the abnormal behavior of psychiatric patients, he must first understand the major aspects of personality, the basic processes underlying personality development, and the normal defense mechanisms. The purpose of this chapter, in which emphasis is on the healthy personality, is to aid the specialist in gaining this understanding.

7. Definition of Personality

Personality is the total sum of the individual—his physical appearance, his awareness of self, and the characteristic way in which he behaves or adjusts to internal and external events or forces. Internal events or forces refer principally to his feelings, emotions, and previous learning; external events or forces refer to the conditions under which he lives. To point out a characteristic of the individual is to assume that there is something relatively consistent about him—a manner of behaving that is repetitive in nature and that occurs in a wide variety of situations.

a. The Behavioral Aspect. The development and functioning of the personality require continuous adjustment to internal and external forces. Since the biological, psychological, and sociological processes involved in this adjustment vary with each individual, each reacts or adjusts to internal and external forces in characteristic ways which are peculiar to him alone and make him different from all others.

b. The Perception of Self. Each individual has an inner awareness of self in which he sees himself as different from all other human beings. This awareness involves not only his physical aspects but also his feelings, thoughts, ideals, and values. It evolves from all the experiences within the individual and with his environment. Development of a healthy concept of self during the early years of life is extremely important in that its subsequent development tends to continue along the same course.

c. The Whole Person. Personality, then, is the "whole person" —his external appearance, his self-concept, and the characteristic ways in which he behaves or adjusts to internal and external forces.

Section II. BASIC FACTORS UNDERLYING PERSONALITY DEVELOPMENT

8. General

The basic factors underlying personality development are heredity and environment. From the interaction of these two factors emerges the individual personality.

9. Heredity

Heredity endows the individual with unique characteristics or differences which influence the development of his personality. These characteristics include the individual's particular size, height, physical strength, appearance, intelligence, general sensitivity, vulnerability to disease, and strength of basic needs or drives. Because of these characteristics, heredity is an important factor in determining how the individual will react to his environment.

10. Environment

The environment is all the physical and social forces—factors, objects, conditions, situations, et cetera—in the life of an individual. The physical environment in which he lives provides possibilities as well as limitations for the growth and development of his personality. The social environment, fostered by people according to their various cultures, affects his patterns of behavior.

11. The Interaction of Heredity and Environment

The hereditary endowment of the individual provides certain potentialities for the development of his personality. The way in which these potentialities are developed and the extent to which they are developed depend upon the forces in the particular physical and social environment in which he lives.

12. Learning

Learning is an important factor in the development of most behavior. Through learning the individual acquires social needs which are important sources of motivation for his behavior. These learned needs and their satisfaction or reward are of great significance in determining the effectiveness or ineffectiveness of the

individual's behavior. There are four major aspects of learning: drive or need, stimulus or what the individual notices, response or what the individual does, and reward or satisfaction of the need. The development of personality involves a lifetime process of learning.

a. Each individual is born with certain basic biological needs which must be satisfied. These include oxygen, temperature regulation, elimination, hunger, and thirst. He also has basic psychological needs which are influenced by heredity but are not the direct result of heredity. These include security, acceptance, love, and self-esteem. The basic needs and their satisfaction serve as the basis for learned needs and their satisfaction or rewards. Learned needs may comprise social status, success, and possessions. These needs may lead to still other learned needs. Each individual has his own particular history of learned needs.

b. Basic rewards or the satisfaction of basic biological needs include such things as food, water, and sleep. The satisfaction of basic psychological needs requires things such as tender loving care. Learned rewards are much more complex. They involve such things as satisfactory interpersonal relationships, acquisition of wealth and social status, achievement in the professions, and success in the business and sports worlds.

Section III. DEVELOPMENTAL TASKS

13. General

The development of personality is a complex process which involves the physical, emotional, intellectual, and social aspects of the individual. This development process follows an orderly individual pattern. To achieve normal and continuous growth in regard to all aspects of personality structure, the individual must master certain major developmental tasks during various periods of early life. Failure to master these developmental tasks during the appropriate periods of time will result in various inadequacies in functioning, which will handicap later development and psychological adjustment.

14. Communication: Nonverbal to Verbal

Communication requires the learning of certain symbols which make it possible for the individual to communicate with and to understand others. It is important to the individual in that it enables him to deal with his environment—to express his needs appropriately, to be aware of and to respect the needs of others, and to perform the social roles which society expects of him.

Language, either written or oral, is one of the primary means of communication. It makes possible the transmission of thought in all forms. Nonverbal symbols such as gestures, intonations, and facial expressions also convey meaning to others; for example, the frown of authority signifies disapproval. The need to communicate through language begins at an early age and grows rapidly as the individual grows older.

15. Dependence to Independence

During the early life of the individual he is completely dependent upon certain adults for the satisfaction of his needs and for the guidance and control of his behavior. It is the parent's "yes" and "no" which tells the child what is accepted by society and what is not. As he develops, he is expected to learn to control his own behavior; that is, to become independent and give up his demand for immediate gratification of needs in favor of more socialized forms of behavior. From a multitude of learning experience the individual acquires the standards of his society and learns to control his behavior and to satisfy his needs through appropriate channels—to substitute independence for dependence.

16. Pleasure to Reality

The term *pleasure principle* refers to the tendency of the individual to seek pleasure and avoid discomfort. The behavior of a young child is considered as being influenced chiefly by the *pleasure principle.* For this reason, he is expected to express his needs immediately and directly. The younger the child is, the less able he is to tolerate situations in which his needs are not met immediately. As he grows older, he learns that needs do not have to be gratified at once and that, in certain situations, he may have to delay gratification in order to work toward more long-range goals. This increased ability to tolerate frustration—the situation in which his needs or desires are not satisfied—is part of maturity. With growing maturity, the individual applies the *reality principle;* that is, he expresses his needs in appropriate ways and does not expect immediate satisfaction. Learning to perceive environment realistically and achieving the ability to face reality are important aspects of personality development.

17. Incompetence to Competence

All through life, particularly from infancy to adolescence, the individual endeavors to master his environment. A great many skills must be learned in order to deal with the adjustment problems which he encounters. His adult adjustment depends to a great degree on how well these skills have been learned.

18. Narcissism to Other-Centered

In this developmental task, the individual must shift from a complete preoccupation with himself and his own needs to an awareness of the needs of others and must develop the ability to respond accordingly. This is a change which occurs gradually and is a sign of growing maturity. The development of this attribute of personality enables the individual to accept responsibility for the welfare of others, such as family and employees.

19. Nonproductive to Productive

In our society the mature and well-adjusted adult is a productive person. He produces in terms of his contributions, such as those to family relationships, in performance of occupational role, and in community affairs. This developmental task is closely interrelated with all other developmental tasks. To be productive, the individual must have attained a degree of independence, be reality-oriented, have achieved a satisfactory level of competence in several areas, and have developed a degree of other-centeredness or empathy.

Section IV. DYNAMICS OF PERSONALITY

20. General

The individual's behavior and his characteristic ways of reacting to his environment are determined primarily by (1) the relationship between the id and the pleasure principle, (2) the relationship between the ego and the reality principle, (3) the superego, (4) and anxiety. The individual is not aware, however, of these forces which influence his behavior.

21. Relationship Between the Id and the Pleasure Principle

The id refers to the basic needs or drives of the individual. The relationship between the id and the pleasure principle is illustrated by the fact that the infant operates on the basis of the pleasure principle, instantly expressing his needs and his dissatisfaction and frustration when they are not fulfilled immediately and satisfactorily (par. 16).

22. Relationship Between the Ego and the Reality Principle

The ego is that part of the personality referred to as the "self." Its function is that of mediating between the needs of the individual and the demands and restrictions of reality. As the child grows older, he becomes able to perceive reality and to understand

that immediate gratification of needs is not always possible. He also becomes aware of the many different ways to meet his needs and learns to choose the better ones (par. 16).

23. Superego

The superego refers to the conscience or the moral attitudes which influence behavior. It is the consequence of all identifications which the individual experiences. As he grows and develops, he identifies with his parental figures and other individuals, learning to accept and disapprove what they accept and disapprove. Because he identifies with many individuals, his moral or superego standards may not be organized consistently or logically. In attempting to satisfy his needs, he selects behavior which does not conflict with his superego standards. If he should select behavior which conflicts with these standards, anxiety results.

24. Anxiety

Anxiety—a phenomenon which takes a very important role not only in personality development but also in psychopathology—is a response to stress. Stress occurs when internal or external events or forces cause a disturbance in the adjustment of the individual. A certain amount of stress in life is unavoidable. The effect of stress on the individual depends upon his interpretation of the stressful situation in relation to his past experiences. The anxiety which he encounters in response to the stress may be described as feelings of dread or fear, but he does not know why he feels as he does. A certain degree of anxiety is normal and necessary in order for him to make adjustment in life. For a more detailed explanation of anxiety, see section II, chapter 7.

Section V. EGO DEFENSE MECHANISMS

25. General

Ego defense mechanisms are forms of behavior employed, usually below the level of awareness, to adjust to stress and resulting anxiety. They are methods of protection from threats to the integrity or worth of self or from any situation which threatens the sense of adequacy or security. Defense mechanisms are used by the well-adapted or mature personality as adjustive measures to deal with various problems. The rigid, exaggerated, or inappropriate use of these measures, however, leads to socially unacceptable behavior and varying degrees of self-deception and reality distortion.

26. Identification

In this mechanism the individual identifies himself with another, attempting to be like him by actually taking over his patterns of behavior. He usually identifies with those who have values, ideals, and other qualities which he admires and desires. Identification begins when the child identifies with parental figures and other family members and continues throughout life as he identifies with many other individuals. This mechanism can be of adjustive value in maintaining self-esteem.

27. Denial of Reality

Denial of reality is a pattern of adjustment involving behavior in which attempts are made to ignore or avoid unpleasant situations. It is a refusal to recognize anxiety arousing situations. Denial may be expressed in everyday behavior, such as by procrastinating, refusing to undertake work in which the individual expects to fail, or becoming so involved with other activities that he does not appear to have time to face the actual problems.

28. Fantasy

Fantasy involves the use of imagination to remake unpleasant situations into pleasant mental images. If it is used to escape temporarily from a stressful situation, it has adjustive value. The use of fantasy can be productive or nonproductive. If it is used to solve immediate problems, as in creative imagination, or to stimulate achievement, it is productive. It is nonproductive when it is used solely as a substitute for realistic gratification of needs and achievement of goals.

29. Compensation

Compensation is a reaction to feelings of inferiority or inadequacy, which may be real or imaginary. It may take the form of an attempt to overcome a handicap or defect by persistent effort or by substituting for, or drawing attention from, the defect through development or emphasis on other aspects of personality. When compensation is used to overcome a handicap and when it is directed toward superior achievement to meet competition, it can be a useful mechanism. It is of no adjustive value, however, when it results in increased anxiety or takes antisocial forms.

30. Rationalization

In using this mechanism, the individual thinks of socially approved reasons for his behavior in order to avoid possible feelings of disappointment and guilt about certain acts and thoughts.

Rationalization is of adjustive value in that it helps to justify certain acts and thoughts and thus lessens disappointment when goals cannot be attained. The use of this mechanism, however, prevents learning from mistakes, since the reasons used to justify behavior are not true ones and energy is used in self-deception instead of learning. When used in extreme degrees, it may lead to false beliefs and delusions.

31. Repression

In repression the individual excludes painful thoughts or desires from his consciousness without being aware of doing so. Although he excludes these thoughts and desires from consciousness, they can be recalled since he does not really forget them. Often the material is not completely excluded from consciousness. Repression differs from suppression, in which the individual consciously puts ideas out of his mind. Repression is helpful in controlling painful desires and in minimizing the effects of painful experiences; however it is of no adjustive value if used in exaggerated form or if used when facing the problem realistically would be better.

32. Reaction Formation

Reaction formation acts as a defense against the possible expression of socially unacceptable behavior. The individual develops attitudes and behavioral patterns which are the opposite of his undesirable motivations. By practicing this "opposite" behavior, the individual is preventing the expression of underlying feelings or impulses which are socially unacceptable. In everyday behavior, reaction formation may be expressed as exaggerated fears, indifference which is assumed to hide feelings of rejection, bravado in times of stress, or overindulgence on the part of a mother whose basic and unconscious motivation is actually rejection. Reaction formation may be of adjustive value when it helps maintain socially approved behavior and feelings of self-esteem. It ceases to have adjustive value, however, when it results in exaggerated fears and beliefs and harsh intolerance of others.

33. Displacement

Displacement involves the transference of feelings which the individual has about a person or object to a different person or object. Destructive criticism of one person, for example, may be a method of expressing hostility meant for another. The individual feels safer by displacing hostility than by directing it toward the person or object causing it.

34. Projection

In the use of this mechanism the individual attributes his mistakes and unacceptable thoughts and desires to his external environment. By blaming something or someone else for his faults, he avoids social punishment. Projection helps him to maintain feelings of adequacy and self-esteem, thus acting as a defense against anxiety. This mechanism, however, prevents the individual from seeing himself in a true light and tends to distort his reality perception of his environment and to create unsatisfactory relations with others.

35. Emotional Insulation

Emotional insulation is a form of protection which involves withdrawing or adopting a passive attitude so as to avoid frustrations and disappointments. The individual takes care to avoid emotional involvement in the attainment of goals and to refrain from engaging in competitive activities so as to avoid possible failure and disappointment. Emotional insulation has adjustive value if it merely lessens disappointment; however when used to an extreme degree, it hinders normal everyday activities.

36. Isolation

Isolation is a mechanism which underlies all intellectual activity. It involves thinking clearly apart from emotion or separating thoughts from feelings. In utilizing this mechanism, the individual may avoid feelings of distress by dealing with a difficult situation such as failure in an abstract manner; he analyzes the causes of failure while rejecting the feelings involved.

37. Regression

Regression is a mechanism which involves reverting to behavior which was appropriate at a less mature level of development. It can be described as a retreat from the reality of the current situation to a state in which accomplishments were more easily attained and social roles were less demanding.

38. Undoing

Undoing is a mechanism which involves making amends or atonements for wrongdoings, such as apologizing, engaging in some form of penace, or undergoing some form of punishment. The ways of making amends may be designed to avoid or to soften punishment. Sometimes punishment itself is considered the only atonement possible. This mechanism is valuable as a defense

against guilt feelings and thus essential in maintaining self-esteem. When used in an exaggerated form, however, it ceases to be an adjustive measure.

39. Sublimation

Sublimation involves the acceptance of a socially approved substitute goal for a drive when the natural channel of expression or natural goal of the drive is blocked. Sublimation is of value in producing socially approved activities when drives or needs cannot be gratified through natural expression. Through sublimation the individual utilizes his energizes in constructive activities.

40. Acting Out

In this mechanism the individual reduces anxiety by acting out or expressing his forbidden desires. In so doing, however, he risks the possibility of guilt feelings and social disapproval and punishment.

41. Sympathism

In this mechanism the individual arouses the sympathy and concern of others by telling them about his difficulties and problems. The concern and sympathy he gets in response help support his feelings of self-esteem.

Section VI. THE MATURE PERSONALITY

42. General

The mature personality is the result of full emotional development. Emotional development depends upon the person's particular biological endowment, the social scene in which he was reared, his special interests, and the emotional experiences felt, particularly during the early years of life. It is also dependent upon mutually rewarding interpersonal relationships and adaptive abilities needed to solve problems and achieve goals. These adaptive abilities include a basic sense of purpose, flexibility of defenses, degree of skills, frustration tolerance, and the ability to discriminate and make wise choices among alternatives in everyday activities.

43. Basic Criteria of Maturity

There is no single set of standards by which the personality can be measured for maturity because what is considered mature varies with different cultures and because no individual is ideally mature

in every respect. Each individual has developed ways of dealing with anxiety which emphasize certain forms of interpersonal behavior and minimize others. The following criteria, however, can be considered basic:

a. In the continuous process of evaluating one's self and society, the individual with a mature personality has a realistic view of both himself and society. He maintains a sense of balance and wholeness while compromising between what is desired and what is realistically possible.

b. He is predominantly independent and responsible.

c. Having self-confidence and self-esteem, he is cooperative rather than egotistical and competitive.

d. He resolves his major conflicts, thus experiencing "normal anxiety" only.

e. Since he uses his defenses constructively, he does not dissipate his energies by rigidly maintaining a protective system.

f. Although he conforms, he does not over-conform to the detriment of his individuality.

g. He uses aggression in constructive patterns by approaching problems with intent to learn and find solutions.

h. He has achieved a balance between independence and dependence, work and play, and giving and taking. Through constructive self-expression he is able to love another as well as himself, to give as well as to receive, and to gain satisfaction from both work and play. He experiences enjoyment in the affection, activities, interests, and responsibilities involved in his relationships to mate, to work, and to friends. He satisfies his needs for approval, recognition, understanding, and acceptance.

CHAPTER 3

MILITARY PSYCHIATRIC SERVICES

44. General

To aid commands in conserving and maintaining the military manpower at the highest level of efficiency, the Army Medical Service provides for the prevention, early detection, and treatment of psychiatric disorders. To the maximum extent possible, services are aimed toward preventing psychiatric disorders and detecting them early. Frequently, psychiatric disorders which are detected early can be effectively treated in clinics on an outpatient basis, preventing the need for hospitalization. Hospital services are provided for patients requiring more intensive psychiatric treatment and care.

45. Hospital Services

In an Army hospital the neuropsychiatric department or service provides diagnosis, care, and treatment for patients with psychiatric and neurologic disorders. Since patients with these two types of disorders require different treatment and care, they are placed in separate wards, which may be located in different parts of the hospital. While psychiatric patients are, in most cases, ambulatory, neurologic patients are more likely to be confined to bed and need nursing care similar to that given any bed patient. Neurologic patients, as well as medical and surgical patients, who also have psychiatric disorders are cared for on a psychiatric ward. Hospital psychiatric services are discussed further in chapter 5. (For special procedures required in providing care for psychiatric patients with other illnesses, including communicable diseases, see TM 8–230.)

46. Psychiatric Team

The psychiatric team in an Army hospital is a group of people who work together toward the same objective—the best possible treatment and care of psychiatric patients. This group of people includes the psychiatrists, nurses, specialists, clinical psychologists, clinical social workers, occupational therapists, Red Cross workers, chaplains, and other personnel from various departments in the hospital. The entire team works in support of the basic

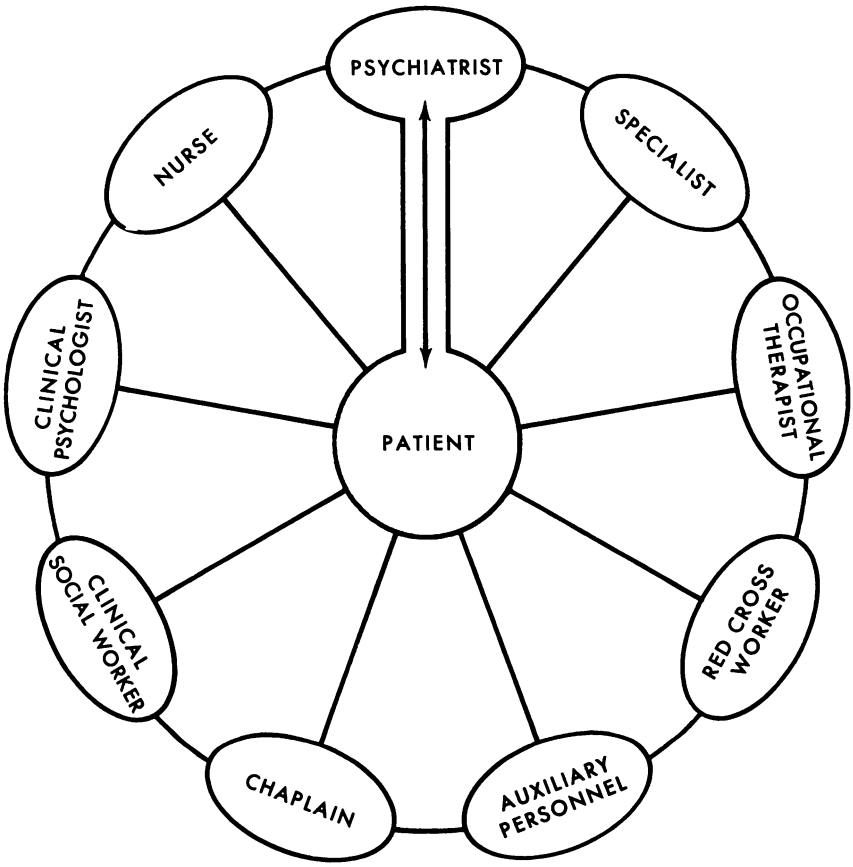


Figure 1. The psychiatric team approach.

therapeutic process which takes place between the psychiatrist and the patient (fig. 1). The team members who have direct responsibility for the day-to-day care of patients and the most contacts with them are the psychiatrists, nurses, and specialists.

a. Psychiatrist. The psychiatrist diagnoses the patients' illnesses, prescribes treatments and medications, and directs the overall treatment programs. He coordinates his own efforts with other members of the psychiatric team. He guides the team members in establishing among themselves and with other hospital personnel the type of relationships which will enable them to communicate freely and to provide the integrated treatment and care necessary to meet the needs of each patient. The psychiatrist has administrative responsibility for the proper establishment, maintenance, and disposition of patients' charts and

records. He is also responsible for teaching residents, interns, nurses, and nonprofessional personnel.

b. Nurse. In cooperation with other team members the nurse plans nursing care to meet the needs of individual patients. She participates in, directs, and evaluates the nursing care. She is responsible for insuring effective ward administration and promoting effective relationships and communications among personnel in the wards and with other personnel who provide specialized services to patients. She assists in formulating in-service education programs, applicatory training programs, and on-the-job training plans. She makes assignments, guides efforts, and evaluates performance of students and assigned personnel under her supervision.

c. Specialist.

(1) With supervision and guidance from the nurse, the specialist assists in meeting the physical care needs of the patients; maintaining a safe, clean, and pleasant hospital environment; creating an emotional climate that is conducive to recovery; supervising patient activities both on and off the ward; administering nursing care; and preparing clearn, concise reports of observations of patients.

(2) The specialist who has the necessary qualifications and experience may be assigned to the position of ward master. As ward master he assists the nurse in orienting, training, and supervising other specialists; coordinating ward activities with departmental activities; planning work schedules; and preparing reports. He also requisitions, maintains, and issues supplies and equipment.

d. Clinical Psychologist. The clinical psychologist aids in patient evaluation, through the administration and interpretation of various kinds of psychological tests. He engages in psychotherapy, both individual and group, under the supervision of the ward psychiatrist, and is also especially trained in the area of clinical research.

e. Clinical Social Worker. The clinical social worker is the liaison between the hospital and the world outside the hospital. He gathers information about the patient's past life and behavior from the patient and his family, friends, and associates and assists individuals such as members of the family and the commanding officer to develop a better understanding of the patient and of the ways in which they can help him make a recovery or adjustment. The social worker helps the patients in the solution of personnel, social, economic, and environmental problems which

impede his recovery and assists him in planning for the adjustment to be made after he leaves the hospital and again becomes an active member of his family and the military organization. He also provides the patient needed assistance during his adjustment period.

f. Occupational Therapist. The occupational therapist plans and conducts physical and occupational activities as prescribed by the psychiatrist to meet the individual needs of the patients and integrates these activities into the total treatment programs. Through these activities of work and play each patient is encouraged to express his feelings in a socially acceptable manner and to participate as a member of a group.

g. Red Cross Workers.

(1) *Red Cross Recreator.* The recreator plans and directs a voluntary, medically approved recreational program which provides patients diversional activities in which they may be spectators or may participate as individuals and members of a group. She encourages patients to participate in planning the activities and utilizes the skills and talents of patients who express a desire to help prepare for activities or take part in programs. She arranges to show the patients current movies weekly and to take them to recreational events off the post periodically. Through the local Red Cross chapter the recreator obtains other entertainment such as musical programs and variety shows and the services of community groups to sponsor parties, teach folk dancing, and conduct tours.

(2) *Red Cross Social Worker.* Working closely with the clinical social worker, the patients, and the national organization staff of the American Red Cross, the social worker provides communication and social services which enhance the health, welfare, and morale of patients as well as their families. The social worker also assists patients in obtaining emergency financial aid and provides patients who do not have funds with comfort articles such as tooth paste and brushes, shaving cream, combs, stationary, postage stamps, and cigarettes.

h. Chaplain. The chaplain provides religious support to the patients. He works closely with other members of the psychiatric team in giving them religious and spiritual guidance.

i. Auxiliary Members of the Team. Personnel in various departments of the hospital perform specialized services which are essential to psychiatric patient care and treatment. Examples of

these services are food, dental, laboratory, X-ray, administrative, and maintenance. Understanding the roles of these team members and establishing and maintaining effective relationships with them are essential in the accomplishment of the total treatment program.

47. Mental Hygiene Consultation Service

a. The Mental Hygiene Consultation Service is a post function, apart from hospital service, under the supervision of the post surgeon. It functions at all posts in the continental United States having the prescribed troop strength. It is also established to meet special needs at such installations as branch service schools and training centers. The primary purpose of the Mental Hygiene Consultation Service is to assist command in keeping soldiers mentally healthy. It is staffed with a team consisting of psychiatrists, clinical psychologists, clinical social workers, enlisted specialists, and clerical and administrative personnel, who work in close liaison with line officers, medical officers, training instructors, and administrative personnel.

b. Through programs of instruction and personal contacts, the Mental Hygiene Consultation Service directs its efforts most specifically toward the line officers who are in the best position to prevent or correct many of the conditions which tend to cause the soldier emotional distress. These conditions include ineffective leadership, lack of proper equipment, inadequate facilities for sending and receiving mail, and unfavorable recreational facilities. The line officers are also in the best position to help soldiers with their emotional problems such as extreme homesickness, excessive worry about loved ones at home, lack of motivation for military life, and poor adjustment to the difficulties of basic training. They may find it necessary, however, to refer soldiers with the more severe emotional problems to the Consultation Service for professional evaluation and treatment.

c. The Consultation Service evaluates and treats all soldiers referred to it and recommends disposition which may be retention in the same assignment, reclassification, hospitalization, or administrative separation. Soldiers are referred to the Consultation Service not only by line officers but also by other persons in direct authoritative contact with them. A soldier may report for help without being referred by anyone; however any action regarding his problem is discussed with his commanding officer.

d. To assist command further in keeping soldiers mentally healthy, the Consultation Service gives lectures, shows films, and conducts conferences for groups of soldiers to help them under-

stand the significance of Army goals, factors which may threaten their adjustment to military life, and how to recognize and handle their own emotional problems. Moreover, it assists commanders to control environmental factors which affect mental health by advising them about assignments, motivation, leadership, training, schedules, food, discipline, and others.

e. The Mental Hygiene Consultation Service also makes evaluations and studies to aid in the correctional treatment, management, and disposition of prisoners who are detained or confined in the post stockade. Each prisoner is interviewed for the purpose of evaluating his intelligence, personality characteristics, and potential for rehabilitation. The results of the evaluations and studies aid in determining the custody grade, remedial work, training, and other confinement programs for each prisoner. They also serve as the basis for making recommendations to the installation commander regarding need for hospitalization, restoration to duty, clemency, or administrative separation from the service.

48. Psychiatric Service at Disciplinary Barracks

The psychiatric service at Disciplinary Barracks aids in the classification, rehabilitation, and management of prisoners. The psychiatric team evaluates each prisoner, hospitalizes those who are psychotic, gives psychiatric treatment as needed, and provides advice regarding other dispositions. This team helps the staff and personnel of the Disciplinary Barracks to understand the behavior of prisoners, to individualize management of prisoners, to appraise the probable effects of confinement, and to predict future behavior, all of which are important in the selection of good programs of rehabilitation, clemency, and parole. In accomplishing these responsibilities, the team keeps in mind that each prisoner has been properly tried and found guilty of a criminal act and that errors and inequities in the system of justice are the rare exception rather than the rule. The team also has the important responsibility of providing information and making recommendations to boards which review and consider the cases of prisoners for the purpose of recommending work assignments, custody status, training, transfer, parole, restoration to duty, and other actions to the appropriate Army commander or The Adjutant General.

CHAPTER 4

THE ROLE OF THE PSYCHIATRIC SPECIALIST

Section I. GENERAL

49. Importance of the Specialist

a. The specialist is an important member of the psychiatric team. He fulfills a role which can influence the patient's recovery as much as any other aspect of the treatment program. This role is that of establishing and maintaining a therapeutic relationship with the patient. (The term *therapeutic,* a qualifying form of the word *therapy* which means treatment, describes that which is remedial, curative, or healing.) A therapeutic specialist-patient relationship is a mutual feeling of interest and trust which enables the specialist to offer a series of planned activities and experiences in a manner that is acceptable to a particular patient and beneficial to his physical, social, and emotional well-being. The therapeutic and professional quality of the relationship is assured only so far as the specialist is aware of what he is doing and why and how he is helping the patient.

b. Although therapeutic relationships between each member of the team and the patient form a basis for the total treatment program, the specialist-patient relationship is particularly significant. The specialist is the one team member who is in constant contact with the patient for sustained periods, helping him to meet his physical and emotional needs as they arise. He is a person with whom the patient can identify and to whom he can express himself freely. The specialist's behavior represents what is "normal" to the patient and serves as a pattern for him to follow. He is a person on whom the patient can practice newly acquired social skills, thus increasing his self-confidence and feeling of security. Other team members depend upon the specialist to follow through with the treatment and care plans for the patient by means of his relationship with him. Moreover, they use this relationship to assure continual observation of how the patient is responding to all forms of therapy.

50. Skills and Principles Employed

To achieve the therapeutic quality of a relationship, the specialist must be skilled in communicating with the patient, in observing

and understanding the patient's behavior, in reporting observations accurately, and in functioning as a member of the team. He must be able to use these skills simultaneously, as each one is dependent upon the effective use of the others. At the same time he must apply the following basic principles of psychiatric nursing care:

a. Accept the patient's behavior exactly as it is.

b. Use self-understanding as a therapeutic tool.

c. Avoid a too-personal relationship with the patient.

d. Use consistency to contribute to the patient's security.

e. Direct observations toward discovering why the patient behaves as he does and what his behavior means to him.

f. Center nursing care on the patient as a person, not on the control of symptoms.

g. Allow the patient to express hostile feelings.

h. Give reassurance in a manner acceptable to the patient.

i. Organize the social structure of the ward unit to promote social participation on the part of the patient.

j. Allow the patient to assume responsibility and become independent as soon as he is ready.

Section II. ESTABLISHING THERAPEUTIC RELATIONSHIPS

51. Basis of Treatment and Care

Therapeutic relationships are the basis for treatment and care of the emotionally disturbed patient. He is in the hospital because he is unable to relate effectively with other people. The difficulties which he experiences in meeting life situations are so stressful and his anxiety is so great that he is incapacitated or ineffective in his relations with others. In the hospital he is away from the environmental stresses with which he is unable to cope and in an environment where social pressure is at a minimum, thus providing him the opportunity to learn to meet his needs in acceptable, satisfying ways and learn again to live with other people in a rewarding manner. This process of re-education is brought about through therapeutic relationships between the personnel and the patient. It entails creating an atmosphere in which the patient is accepted as a person exactly as he is, in which his behavior is calmly accepted as an expression of his illness, and in which he feels no threats. It requires providing the kind of experiences that lessen the patient's need for continuing his present pattern of behavior; that help him acquire a more realistic understanding of himself, his environment, and his relations with others; and that enable him to realize success in interpersonal relationships. It means

helping him to assume gradually more responsibility for himself, to develop initiative, to make decisions in a more realistic way, to channel his emotions more constructively, and to make better use of his capacities and potentialities.

52. Importance of Attitude

a. Forming a specialist-patient relationship which is therapeutically effective depends to a great extent upon the attitude of the specialist. First and foremost, his attitude must be one of acceptance. He must accept the patient before he can attempt to understand his behavior or to communicate with him. He must accept the patient's behavior without passing moral judgment and without making him feel that he has offended and should be punished. Acceptance does not mean that the specialist necessarily approves or condones the patient's behavior but that he recognizes it as the patient's exaggerated way of relieving his anxiety, of satisfying his unfulfilled needs, and of informing others of these needs. He accepts it as the patient's desperate attempts to achieve satisfaction in the only way he has left to him. To show irritation or disapproval of the patient's behavior would only make him feel more convinced that on one really cares about him. Only in an accepting atmosphere is the patient able to view his behavior objectively and come to realize that his defensive actions are unnecessary.

b. The specialist's attitude must also be one of sincere desire to help and guide the patient toward recovery. The sincerity of his attitude influences the patient's attitudes toward him. It is, therefore, a major factor in the development of mutual feelings of interest and trust. The specialist may have to prove to the patient over and over again that he is interested in him and that he can be trusted.

53. Importance of Self-Understanding

The specialist must be aware that it is possible for a patient's behavior to arouse in him such emotions as fear and anger and for his emotional responses to cause the patient to feel more frustrated and rejected. This does not mean, however, that the specialist cannot bring his emotions under control. He must realize that the patient is the one who has become unable to control his emotions and who must act out his feelings. He must face his own difficulties realistically; he must apply what he knows about human behavior to his own behavior and feelings and come to understand himself. Exchanging experiences frankly with other team members is often helpful to the specialist in gaining an insight into the emotional responses between him and the patient and a better understanding of himself.

54. Development of the Therapeutic Relationship

In developing a therapeutic relationship, the specialist and patient pass through three stages, each one phasing into the other. The stages are referred to here as the formative or getting-acquainted period, the dependent or supporting period, and the independent or setting-free period.

a. Formative Period. During the formative period the specialist and patient become acquainted and establish rapport. The specialist, of course, takes the initiative and sets the tone of the relationship. From the beginning he avoids making the relationship too personal because such a relationship is not conducive to a therapeutic atmosphere. The patient is looking for security, not intimacy. A professional relationship not only gives the patient a greater feeling of security but also protects him from demanding more than he can possibly receive and feeling betrayed as a consequence.

(1) With an accepting, sincere attitude the specialist lets the patient know that he wants to help him. At first he visits the patient frequently but for only short periods of time. This gives the patient an opportunity to get to know the specialist and to learn what he can expect from him. Each time the specialist leaves, he tells the patient that he is going and that he will be back. He also gives him some indication of the time he plans to return. He must not fail to return even if it is just to tell the patient that he is unable to visit as promised. It is actions such as these that help the patient acquire the feeling that he can trust the specialist. During these visits the specialist observes the patient and listens carefully, noting how the patient responds to him, what he does or does not talk about, and how he seems to feel about his illness and his present environment. He is alert to the patient's concerns, fears, patterns of behavior and thinking, and obvious physical symptoms. He directs his observations toward discovering the "why" and "what" behind the patient's behavior. He attempts to understand why the patient behaves as he does and what his behavior means to him (sec. III). The specialist's observations of the patient are not only essential to the therapeutic effectiveness of his relationship with the patient but also valuable to the psychiatric team in determining a tentative treatment program for the patient.

(2) During this getting acquainted period the patient may attempt to evoke negative feelings from the specialist. This may be the patient's way of testing the specialist to

learn if he can really trust him. On the other hand, behavior which appears to be an attempt to provoke the specialist may be the patient's response to the specialist's attitude toward him. Sometimes the specialist's expectations and preconceptions of the patient are affected by statements that other people have made or by his own needs and wishes. The specialist may feel that the patient is too unconcerned and inappreciative of his efforts to help him. He must, therefore, examine his own feelings about the patient, recognize the patient's behavior as an expression of his illness, and accept the patient's behavior as it is. He must be consistent in his relationship with the patient. Since the patient is basically insecure and uncertain, he needs to be able to anticipate the specialist's attitude toward him as well as the climate of the environment.

b. Dependent Period. Once the patient feels that the specialist is genuinely interested in him and that he can depend on the specialist for both emotional and physical support, he becomes a dependent participant in the relationship. Inevitably, this dependence brings about regression, which may make the patient seem childlike in his dependence. The specialist, therefore, must expect and accept regression as another aspect of the patient's illness.

(1) By the time the patient has reached the dependency stage, the specialist is familiar with the patient's particular behavior pattern—his characteristic way of handling stressful situations. At this time he directs his efforts toward helping the patient to behave in a more acceptable and rewarding manner, while the psychiatrist and nurse direct their efforts more toward helping the patient to reorient his thinking and emotional patterns. The specialist listens to the patient carefully and helps him express his feelings and work through his problems. He does not, however, encourage the patient to express problem areas that are beyond his responsibility, ability, or skill. The specialist should seek guidance from the nurse any time that he is not sure whether or not a problem area is beyond his responsibility.

(2) Many nursing care problems arise during the dependent period. The patient may become generally resistive. He may complain excessively, refuse to participate in activities, demand an unusual amount of the specialist's time, manipulate situations that he thinks will provoke the specialist, or show hostility toward him. This behavior has meaning, but the meaning is not the same for any two patients. The specialist must, therefore, approach each

patient's behavior on an individual basis and center nursing care on the patient as a person, not on the control of symptoms. In fact, dealing with behavior without proper consideration of its meaning can bring adverse results and complicate the problem. Nursing care of patients with various patterns of behavior is discussed in detail in chapter 7.

(3) It is important for the specialist to remember that during this dependent period, the patient's improvement will not necessarily be a steady progression. Sometimes it may seem to the specialist that the patient takes one step forward and two backward. The specialist must not become discouraged, because each sign of improvement is important no matter how small or temporary it may be. Small and temporary changes lead to more permanent, mature ways of behaving. Even though the patient suddenly rejects the specialist, it does not mean that the previous constructive experiences are lost, because they have most likely left the patient more accessible and better able to relate again.

(4) During this dependent period the specialist allows the patient to express hostile feelings. He can usually channel the expression of these emotions by guiding the patient into physical or occupational activities in which he can find an outlet for pent-up hostility and aggression. For example, the patient may be able to get relief by pounding and hammering on metal and wood in the occupational shop, punching a bag, or bowling. The patient may get needed relief by being permitted to express his negative emotions verbally toward the specialist. Allowing the patient to discharge his emotions without fear of retaliation helps him to become more objective about experiences which arouse his hostility and about the ways in which he expresses his emotions.

(5) Throughout this dependent period the specialist gives the patient reassurance in a manner acceptable to the patient. This is more than telling the patient that he will get well, that his fears are unfounded, and that he is a worthwhile person. Such verbal reassurance is effective only when it does not contradict a belief that the patient needs or that he has firmly implanted in his mind. Possibly, the most acceptable reassurance that the specialist can give the patient is to show interest in him, to take care of matters that are important to him, and to allow him to be as sick as he needs to be.

c. Independent Period. The patient reaches the independent stage when he becomes less anxious, better oriented to his environment, and more realistic and effective in dealing with it; when he acquires more insight into himself, has fewer or less severe symptoms, gets along better with other people, and communicates more easily; and when he feels that he is a more worthwhile person. During this independent period the specialist is particularly careful to organize the social structure of the ward unit in a way to promote social participation on the part of the patient. As the patient has satisfying experiences, new personality patterns emerge; he thinks differently and relates to other people in a more mature way. He becomes able to make at least simple decisions and choices and to assume more responsibility for his own care. The specialist allows the patient to become more and more independent. Frequently the patient indicates, sometimes pointedly, that he no longer needs the specialist to help him. If the patient does not express in some way his readiness for independence, the specialist begins gradually withdrawing as he forsees the patient's readiness for independence approaching. In doing so, he gradually decreases the amount of time that he spends with the patient. He may also decrease the intensity of the relationship by tactfully displaying an attitude of more casual friendliness toward him. As the specialist withdraws, the patient's contacts with other persons begin to play a more prominent role in his environment and daily care.

Section III. UNDERSTANDING THE PATIENT'S BEHAVIOR

55. General

a. Only with an understanding of the patient's behavior can the specialist provide the patient the experiences which will lessen his need to continue his mentally ill behavior and the guidance which will help him learn more acceptable, satisfying ways of meeting his needs. Although the patient is neither so delicate that one experience devastates him nor so insensitive that he is unaffected by any one experience, his recovery is greatly dependent upon the therapeutic experiences made possible through understanding.

b. Essential to this understanding is an awareness of how the patient feels about himself and his hospitalization. Characteristically, he has a low opinion of himself; he feels inferior to other people even though he may cover this with delusions of grandeur. He is confused, anxious, and lonely. He believes that his life is one of defeat and failure, resulting in utter hopelessness, helplessness, and resentment. He is fearful of both his surroundings and himself. Realizing that he has little control over his behavior, he is

afraid of what he might do. On the other hand, he is distrustful and suspicious of the attitudes of others toward him because he believes that no one really cares about him and that he is suffering misery which no one understands. Although he has an intense, desperate need for warm friendly relations, he fears that he might be disappointed and hurt if he allows the creation of a close relationship with anyone. Frequently, he feels guilty about his strong negative feelings and may feel the need for punishment. With all these emotions he, of course, feels insecure. He is afraid of being ignored, rejected, or slighted; these fears greatly affect his response to treatment and care. For example, the patient who fears being rejected and disappointed may openly manifest rejection himself in an attempt to test the sincerity of any person who tries to show him the kindness and attention he needs.

56. Meaning of Behavior

a. The patient's behavior is a pattern of exaggerated defense methods, which he uses in a desperate attempt to handle his severe distress and anxiety; to fulfill his needs such as those for security, approval, acceptance, social status, love, and affection; and to inform others of his unfulfilled needs. Although the patient's behavior may appear pointless, it serves a definite purpose and has a unique meaning to him. It is this purpose and meaning which the specialist must continually seek. In discovering the "what" and "why" of behavior, the specialist must avoid accepting superficial reasons for behavior. For example, to assume that a patient who draws pictures of stick-men on the ward walls is a troublemaker, purposely annoying the specialist who has to clean the walls, is a superficial reason. Acceptance of this superficial reason could lead to a detrimental response such as trying to teach the patient that it does not pay to make work for the specialist. On the other hand, the specialist who seeks, through close observation, the "why" and "what" of this behavior may learn that the patient is telling the personnel that he needs contact with people and has resorted to fantasy people in preference to those who he feels ignore him. To another patient such behavior may be an attempt to return to his former artistic way of expressing himself. The reasons behind similar behavior of any two patients are different. Learning these unique reasons entails finding out what the behavior accomplishes for each patient. For example, several patients may be uncooperative, but understanding is possible only by knowing what each patient accomplishes by being uncooperative. Is the patient avoiding a relationship in which he feels he might be hurt? If so, why? Does being uncooperative satisfy a need to hurt others? If so, why? Does the patient see other people

as a threat to him? If so, why? In seeking these answers, the specialist must avoid projecting his own emotions into them. Since the specialist needs to understand behavior from the patient's point of view rather than his own, he must learn to put himself mentally into the patient's place and determine what the behavior might be accomplishing or seeking if he were the patient. This is the process called empathy.

b. It is through familiarity with each patient's behavior and the continual search for the reasons behind it that the specialist comes to understand the patient's general behavior pattern sufficiently to provide him the corrective experiences that he needs to help him recover. The general behavior patterns of patients differ radically. One patient may withdraw from all contact with other people and the environment; whereas another patient may become openly hostile and aggressive. The nursing care made possible through understanding the different patterns of behavior is discussed in chapter 7.

Section IV. COMMUNICATING WITH THE PATIENT

57. General

Communication is the act of imparting thoughts, ideas, information, attitudes, and feelings from one individual to another. It may be verbal, nonverbal, or a combination of both. It is an integral part of the specialist-patient relationship. In fact, the therapeutic effectiveness of this relationship is greatly dependent upon the specialist's skill in communicating with the patient. To understand and relate to the patient, the specialist must be able to communicate with him. This is not easy because his illness involves, in part, a defect in communication.

58. Factors Influencing Communication

The patient may be unable to use certain communication methods or have difficulty in doing so. He may be unable to verbalize because he is mute or may have difficulty in doing so because his words do not flow freely. He may have a language barrier. For various reasons he may be unable to write. Frequently, the patient lacks the energy and the desire to express himself. Another factor influencing communicating is the patient's inability to listen and understand what other people are saying to him. He may be so completely preoccupied that he is unable to listen, concentrate, or reason; his attention span may be too short to comprehend more than a few words at a time. There may be interference from hallucinations; the patient may receive false sensory communications that offset any person's attempt to communicate with him. He may be delusional, in which case his fixed, false beliefs take precedence.

59. Means of Communication

When the specialist and the patient are in contact, the communication is continuous. The patient is telling the specialist something by everything he says and does; the specialist is, likewise, telling the patient something through his behavior as well as spoken words. Gestures, stance, and facial expression, as well as actual words, convey meaning. Verbal communication is usually easier to interpret and understand; however nonverbal communication is frequently a more accurate description of true attitudes and feelings. For example, a patient may say that he is feeling fine when his facial expression and body posture indicate he is sad. The specialist may pretend to be interested in the patient, but his body posture and general attitude tell the patient whether or not he is genuinely interested.

a. Nonverbal Communication.

(1) In communicating with a patient who does not talk, the specialist must focus his attention on his behavior. He must learn what the patient is expressing through his relaxed or tense muscles, pale or flushed face, the expression in his eyes, the way he shifts and tilts his body, et cetera. In observing such movements, the specialist attempts to understand what they mean to the patient rather than what they mean to him.

(2) Nonverbal communication becomes easier as the specialist gets to know the patient better and becomes familiar with his characteristic patterns of behavior, attitude, and response. For example, a mother understands perfectly well what her infant is expressing long before he is able to talk. She can interpret vague gestures that are completely unintelligible to other people. Friends often answer each other's questions with characteristic gestures which are understood by them but not by strangers. There are also gestures which are characteristic of locales and cultures as well as gestures which have different meanings in various locales and cultures.

b. Verbal Communication.

(1) To converse effectively with the patient, the specialist must have a specific purpose in mind. The initial conversation with the patient is usually for the purpose of getting acquainted. The specialist attempts to find out as much as possible about the patient by showing genuine interest in him as a person, but at the same time he avoids probing into personal affairs which the patient is not ready to discuss. Sometimes the specialist encourages

conversation merely to relieve monotony of ward routine. In this case, he guides the conversation toward impersonal subjects such as previous or planned entertainment, excursions, and hobbies. When the patient is waiting for an appointment or treatment, the purpose of the conversation may be to make the patient feel more comfortable; it may be to find out how the patient feels, to obtain or provide information, or to divert the patient's attention from certain thoughts.

(2) The specialist follows the same rules in conversing with a patient as he does in any social conversation. He is polite, pleasant, and interested. He offers ample opportunity for the patient to participate. He lets the patient lead in choice of topic and in lengh and depth of discussion of each topic. Unless the patient becomes tense or anxious, the specialist does not change the topic, as doing so may represent rejection to the patient.

(3) Communicating with a psychiatric patient without giving him a disturbing answer or response often requires the skillful use of the reflecting technique. This is an effective method of turning the patient's question back to him or rephrasing his statement into a question. For example, when a patient tells the specialist that a light switch is a recording device, he expects a verbal response. Depending, of course, upon the existing circumstances and the individual patient, the specialist might respond by saying something as vague as "A recorder?" Such a response encourages the patient to continue to express himself. The specialist might also discourage the patient's delusional thinking without disturbing him by saying, "I realize that you believe this, but I see it only as a light switch for turning on and off the lights. Does it bother you to think of it as a recorder?" In this response the specialist is acknowledging the patient's right to his belief, giving him a more realistic point of view, and at the same time encouraging him to express his feelings rather than delusional thoughts.

60. Importance of Listening

a. Listening to the patient with interest is one of the primary aspects of communication. It makes the patient feel free to express himself in whatever way he can at the moment. Such spontaneous expressions help the patient to release his emotions and possibly lessen his need to act them out. Through attentiveness to the patient the specialist is able to become familiar with the patient's

way of expressing himself and to concentrate on what the patient is attempting to say, what is happening to and within the patient, to and within himself, and between himself and the patient.

b. It is not always easy to listen attentively to the patient because he often speaks in a vague, detailed, or repetitious manner. Unless the specialist is alert to this fact and makes a decided effort to listen, he may respond to the patient's words without listening to what he is trying to say. It is also possible for the specialist to unconsciously reject the patient by not listening to him. He may do this because he senses that the feelings underlying the patient's talk are hostile toward him and he has difficulty in accepting this.

c. When the specialist cannot understand the patient, he should not become discouraged, because the mere experience of being together and attempting to work out a communicative exchange is, in itself, therapeutic to the patient. It helps satisfy the patient's need for attention and respect and makes him feel more accepted and worthwhile. In fact, the patient may at times attempt to communicate with the specialist not because he wants to give him a message but because he wants attention and companionship or needs to ventilate his feelings.

Section V. USING PSYCHIATRIC TEAM RELATIONS

61. General

To achieve the therapeutic qualities of a specialist-patient relationship, the specialist must be skilled in functioning as a team member. He must understand the meaning of the team concept, the purpose of the team approach, the overall responsibilities of the team members, the need for harmonious relationships, and his specific responsibilities as a member of the team.

62. The Psychiatric Team Concept

The psychiatric team concept is that a group of associates can best achieve the treatment goal by sharing the responsibility for effectiveness of the treatment program and by working together so that each individual makes the maximum contribution. The psychiatric team members work in close cooperation toward the treatment goal of returning patients to society as well equipped as possible, physically and emotionally, to take their places as productive members.

63. Purpose of Team Approach

The team approach is a way of providing the patient with the best treatment and care program possible. Through group planning and coordination the many team members (par. 46), each

with special knowledge and skills, are able to achieve continuity in the total program for the patient, maintain consistency in the overall approach to him, avoid duplication of efforts, and provide better service to the patient.

a. Continuity. Continuity in the total program for the patient means that all aspects of treatment and care phase smoothly into one another. Team members accomplish this by planning the integration of their services and by coordinating their efforts through informative and comprehensive communication.

b. Consistency. Although the individual members carry out different aspects of the total treatment and care program, they maintain consistency in their approach to the patient through coordinated planning. For example, if the therapeutic plan for a patient is to encourage him to test reality, all members direct their services accordingly, thereby maintaining the therapeutic effectiveness of the total treatment and care program.

c. Avoidance of Duplication. Duplication is not only annoying and confusing to the patient but also wasteful. Team members, who plan together for the patient's treatment and care, are made aware of each member's delegated responsibilities and of how the various aspects of the program supplement and complement one another. With such an awareness they are able to communicate more effectively and avoid duplication of effort.

d. Better Service to the Patient. The team approach results in the avoidance of a hit-and-miss way of attempting to carry out a therapeutic care program. When team members share their knowledge and understanding and work harmoniously together toward a common goal, the patient is the recipient and a participant in the best possible care program.

64. Need for Harmonious Relationships

The team members, who are dependent upon one another for effective results, must work harmoniously together. This requires a sharing of responsibilities and of strengths, a spirit of give and take, and a sense of mutual respect. Each member must understand the role of the other members—where and how each member functions in the overall treatment and care program for the patient. There must be informative and comprehensive communication between team members of the same and different departments. Their interest must be group-centered; otherwise the patient is the victim of poorly integrated care resulting from disharmony and conflicts among the team members. To enhance congenial relationships, each member must understand and accept the fact that people approach and respond to one another according to

the way that they perceive themselves and interpret the actions of others.

65. Team Planning for Patient Care

Together the psychiatric team members plan a treatment and care program for each individual patient. As often as necessary they meet to share their observations of the patient and their experiences with him, to identify as best they can the needs of the patient, and to determine the best ways of meeting these needs. They share their knowledge and understanding of the patient and discuss the patient's responses toward the hospital environment, therapies, activities, personnel, visitors, et cetera. They evaluate the effectiveness of previously planned care and, if indicated, modify plans to fulfill more effectively the patient's needs. The planning phase is not complete until the team members have a common understanding of each member's role in executing the program in a coordinated, integrated manner. The group meetings may also be used to check the progress of the patient periodically throughout his hospitalization, to clarify misunderstandings, to discuss areas in which disagreements exist, and to help obviate personal difficulties in providing nursing care.

66. Responsibilities of the Specialist

a. In order for the specialist to function as an effective member of the psychiatric team, he must maintain his own physical, emotional, and intellectual fitness. His physical health is dependent upon a well-balanced daily program of work, diet, play, and rest. His intellectual and emotional fitness, which is determined largely by his attitude and philosophy of life, must include a deep sense of self-respect, respect for others, and an appreciation of his work in caring for the mentally ill.

b. As a team member the specialist has certain obligations, all of which entail the ability to work harmoniously with other members. When the team members meet to plan patient care, the specialist makes definite contributions by reporting accurately and objectively his observations of the patient, by listening attentively to reports of other members, by discussing the possible meaning of observed behavior, and by offering suggestions in planning the therapeutic program for the patient. When the specialist escorts the patient to an activity for which another team member is responsible, he provides information which may be helpful in dealing with the patient. He shows the team members consideration by having the patient present at the designated time and by having prepared the patient physically and psychologically for what is to take place. Preparing the patient psychologically entails being

sufficiently aware of the therapeutic value of the particular activity to be able to encourage the patient as to its importance in a way which is meaningful and convincing. During the specialist's prolonged and close daily contact with the patient he represents the team and, through interpersonal relations with the patient, frequently brings about cohesiveness of the treatment and care program by guiding the patient through the day, phasing one activity into another without confusion and delay.

c. The specialist also has the important responsibility for safeguarding the confidentiality of information regarding the patient. He does not discuss this information with anyone except other members of the psychiatric team. When he has the patient's personal history or clinical records in his possession, he takes precautions to be sure that no unauthorized person reads them and releases them to only authorized individuals.

Section VI. OBSERVING AND REPORTING

67. General

Careful observation and accurate reporting of the patient's behavior is one of the specialist's most important duties. Since he is with the patient in more diversified situations and for longer periods of time than any other member of the phychiatric team, he is the primary observer of the patient. The psychiatric team depends upon him to observe the patient's reactions to therapies, activities, personnel, other patients, and the environment in general and to report these reactions accurately. The specialist's reports are of great value to the team in identifying the needs of the patient, in planning a treatment and care program for the patient, in evaluating the progress of the patient and the effectiveness of the program, and in detecting significant symptoms of physical illness. They are also an aid to the psychiatrist in determining the diagnosis of the patient. They may be used by research workers in psychiatry and, in some cases, may serve as legal documents.

68. ABC of Observing and Reporting

The value of the specialist's reports is greatly dependent upon his skill in observing pertinent details about the patient and in reporting them accurately. In order for the specialist to become skillful in doing this, he must direct his attention toward the patient's appearance, behavior, and conversation — frequently called the ABC's of observing and reporting.

a. Appearance.

(1) *Facial expression.* Is it sad, cheerful, frowning, strained, pinched, mask-like, haggard, or alert? Does the patient

look frightened, preoccupied, bewildered, silly, or questioning?

(2) *Personal hygiene.* Is the patient clean or dirty? Does he have body odor or use perfume? Are his hair and nails well groomed?

(3) *Dress.* Is he neat or careless in his dress? Are his shoes polished? Does he wear his clothes in a distinctive manner, such as the collar turned up, the shirt open several inches, or the legs of pants rolled up? Does he add decorative touches to his dress?

b. Behavior.

(1) *General behavior.* Is it consistent with his facial expression and dress? Is he excited, irritable, quarrelsome, gay, friendly, or mischievous? What is his attitude toward personnel, other patients, environment, and family?

(2) *Movements.* Are his movements fast, slow, smooth, jerky, clumsy, graceful, determined, or uncoordinated?

(3) *Gait.* Are his steps light, heavy, jerking, dragging, staggering, bouncing, strutting, limping, striding, or running?

(4) *Activity.* Is he restless, composed, meddlesome, destructive (if so, of what), assaultive (if so, of whom), noisy, or distractible? Does he assume strange postures, sit or stand in one position for long periods, remove his clothing, laugh or cry for no apparent reason, decorate himself or the room with food, feces, or articles? Does he respond well to directions? Is he able to carry out tasks that he assumes or that are assigned to him? Does he show initiative and originality in any occupation? Does he finish a job that he starts? What kind of occupation and recreation does he seem to prefer? Does he work and play well with other patients, or does he do better alone? What are his eating habits? Does he eat too much or too little? Does he need to be urged to eat? Must he be spoon fed? What kind of table manners does he have? Does he disturb other patients at the table, or is he easily upset by other patients when eating? What are his sleeping habits? Does he sleep excessively or very little? Does he sleep soundly, or is he awakened easily? Does he sleep quietly, or is he restless? When he awakens, is he alert and refreshed or sleepy and tired?

c. Conversation.

(1) *Amount.* Does he talk most of the time, a little, just in answer to questions, or not at all? Does he initiate conversation?

(2) *Rate and tone of voice.* Does he speak rapidly, slowly, hesitantly? Is his voice loud, moderate, low, or monotone?

(3) *Content of speech.* Does his speech make sense? It it rambling? Does he change from one topic to another or include many unnecessary details? Does he express suspicions, threats, profanities, or obscenities? Does he complain of other patients, objects, or activities in the environment? Does he mention remarks made by unseen persons, or does he talk to unseen persons? Does he show in his speech that he is aware of the date, whe he is, and where he is? To whom does he speak? Does he speak to himself, or to a particular person? Does his speech show that his memory is good or poor?

69. Reporting Observations

a. The specialist reports his observations not only in writing but also orally, depending upon the circumstances or need to do so. For example, he immediately reports orally any signs or symptoms of physical illness or any behavior which is a possible indication that the patient may be contemplating suicide.

b. To insure accuracy and completeness, the specialist should record his observations as soon as possible after they are made and include all important information. Even the slightest change in the patient's behavior is important to the psychiatric team in planning treatment and care. The specialist should not, however, report anything which he has not personally seen or heard. The following rules serve as a guide in reporting observation of patients:

(1) Be objective. Do not let personal feelings about the patient interfere with the reporting of actual facts about his appearance, behavior, or conversation.

(2) State exactly how the patient appears, exactly what he does and, to the extent possible, quote the exact words he uses. Avoid giving interpretations, as this requires the skill of a psychiatrist.

(3) State facts in a concise manner and in words which any one can understand. Do not use trite remarks and slang unless they are direct quotes. Do not use technical terms. For example, instead of saying that the patient is hallucinating, state what he is doing or saying.

(4) Write in a neat, legible manner; spell and abbreviate words correctly.

(5) Safeguard the confidentiality of the record.

CHAPTER 5

THERAPEUTIC HOSPITAL ENVIRONMENT

Section I. GENERAL

70. Concept of a Therapeutic Environment

a. A therapeutic environment, within the hospital setting, is an environment in which the patient feels safe and comfortable and is provided opportunities for emotional growth. This concept has developed in recent years partially as the result of changes in the beliefs and attitudes of the hospital personnel toward the mentally ill. Most influencing has been the change from the pessimistic attitude of "hopeless pity" to a strong belief in the patient's capacity to recover from a mental disorder.

b. To provide a therapeutic environment, the members of the psychiatric team must have an understanding of human behavior to help them comprehend why the patient behaves as he does and accept the patient's behavior as a manifestation of his illness. They must help the patient to resume interest in the world about him and to learn more satisfying and acceptable ways of behaving.

71. Characteristics of a Therapeutic Hospital Environment

a. It provides for the patient's immediate needs. For day-to-day living the patient is provided food, fluids, clothing, exercise, rest, and medical care.

b. It provides for hygienic care. The patient's surroundings are kept sanitary. He is provided toilet, bathing, and grooming facilities and given needed assistance in maintaining good personal hygiene and appearance.

c. It provides protection. The patient is protected from injuring himself and others, from being injured by others, and from intolerable anxiety provoking situations which threaten his security and self-esteem.

d. It is accepting. Regardless of the patient's behavior, he is not judged good or bad. He is accepted as a human being of worth with the right to like or dislike and to accept or reject some aspects of his hospitalization.

e. It is democratic. Fewer restrictions and more freedom of choice are provided the patient as he becomes able to assume more responsibility for his own actions.

f. It serves as a testing ground for learning more mature patterns of behavior. The patient is allowed to express negative feelings without unnecessary limits or inhibiting routines and attitudes. In his relationships with the hospital staff, he has opportunities to test his attitude and behavior and to learn that much of his defensive behavior is unnecessary.

g. It provides for therapeutic activities. Activities which will enhance the patient's feeling of security, worth, and acceptance are planned and carried out as an integral part of the total treatment program.

h. It provides consistency. In order that the patient will feel more comfortable and secure, daily routines and hospital activities are carried out according to a plan. The members of the psychiatric team strive for consistency in their approach to him; they strive to furnish an environment upon which he can depend. Consistency in unemotional enforcement of environmental limitations is an effective method of contributing to the patient's security.

i. It provides for spiritual support. Religious services and guidance are made available to all patients according to their personal preference.

Section II. BASIC ASPECTS OF A THERAPEUTIC ENVIRONMENT

72. Psychiatric Wards

Since psychiatric patients vary from those with acutely disturbed behavior to the convalescents, both closed and open wards are provided. Every effort is made within realistic limits to create in these wards an atomosphere of warmth, relaxation, and acceptance. Color, music, pictures, and flowers are used to help give the wards a homelike atmosphere.

a. Open Ward. The open ward is provided for patients who are able to assume responsibility for their own behavior and for other aspects of their daily care. Although they need understanding, guidance, and support from the entire psychiatric team, they are held responsible for taking care of their own personal hygiene, getting to their meals and appointments on time, attending required activities, and being on the ward during specified periods such as those designated for ward rounds, treatments, and medications. Open ward patients are given the freedom of the hospital

grounds. They are encouraged to attend community activities such as movies, plays, sports events, and symphonies without supervision of the hospital staff. This helps them develop self-confidence and provides the psychiatrist an apportunity to evaluate their ability to conduct themselves in acceptable ways without guidance.

b. Closed Ward. The closed ward is provided for patients who cannot control much of their behavior, who need protection from emotional stress which they are unable to tolerate, and who require a great deal of guidance and assistance in caring for their personal needs. The closed ward is, therefore, designed and managed to afford maximum protection, guidance, and assistance. All doors are kept locked, including the doors to the utility, linen, supply, and treatment rooms. Windows are protected by strong screens. Articles that could be used by patients to harm themselves and others or to escape are used only under strict supervision and are carefully accounted for. Any time closed ward patients participate in activities off the ward, they are accompanied by a responsible person, most frequently the psychiatric specialist.

73. Communication Facilities

The availability of communication facilities enables the psychiatric patient to maintain relationships with people who are an integral part of his life. Every patient is encouraged to communicate with his family and friends unless doing so would create emotional stress from which he is being protected until his condition improves.

a. Mail.

(1) The open ward patient mails his own letters and packages. The nurse mails letters for the closed ward patient, and the Red Cross worker or occupational therapist assists him with packages. The psychiatrist or nurse reads the closed ward patient's letters and decides whether or not they should be mailed. Because of his illness, he may make statements which could cause him inconvenience or embarrassment. The fact that his letters are read is explained to him at the time he is asked to leave the envelopes unsealed. If the patient's letters are not mailed, they are either returned to him or filed in his clinical chart. The patient is told why his letters were not mailed and is encouraged to continue writing letters. Any time a patient gives the specialist letters that he has written, the specialist does not read them but delivers them directly to the nurse. He never, under any circumstances, mails letters or packages for a patient without permission of the nurse.

(2) Incoming letters and packages are kept in a locked place until a designated time when they are delivered directly to the patient. Mail is never left at the bedside or given to another patient to deliver. The closed ward patient opens his letters and packages in the presence of the specialist or nurse. The specialist who supervises the patient while he opens his mail has certain responsibilities. If the patient receives distressing news, he gives him emotional support. He turns in to the nurse any money and valuable papers that the patient receives. When a package contains hazardous articles, he explains to the patient that he is not permitted to keep them on the ward but that they will be stored and made available when he needs them or that they will be given to him when he is transferred to an open ward or he leaves the hospital. If a package contains food that requires storage, the specialist labels it and puts it in the ward refrigerator. He removes the package wrapping and string from the ward.

b. Visitors. The policies governing visitors and visiting hours are established locally. Ordinarily, the open ward patient is permitted to visit with his guests on the post any time that he is not required to be on the ward. The closed ward patient receives his guests in the visiting room. His visitors are restricted to members of his immediate family. Any other person who wants to visit him must have permission from the psychiatrist. The closed ward patient is escorted to the visiting room where he is supervised by the specialist assigned to this room. The specialist observes the patient's behavior and reaction to his visitors. If the patient does not wish to visit, the specialist does not insist but calls the nurse to send someone for him. The specialist is always courteous, pleasant, and kind to all visitors. He refers a visitor who wants information about a patient to the patient's psychiatrist or the nurse. He checks all packages which visitors bring to a patient.

c. Telephone Calls. The open ward patient is at liberty to make and receive telephone calls. The closed ward patient must have permission of the psychiatrist to make and receive telephone calls. The specialist escorts the patient to the telephone, assists him, if necessary, in using the telephone, and returns him to the ward. Although the specialist remains with the patient while he is using the telephone, he does not listen to his conversation unless the psychiatrist or nurse specifically tells him to do so.

Section III. THERAPEUTIC ACTIVITIES

74. General

Therapeutic activities are an essential part of the hospital environment. They are provided to assist the patient in his emotional, social, and physical rehabilitation. They are designed (1) to arouse interest, (2) to exercise the mind and body in healthy ways, and (3)to help overcome disability and re-establish capacity for industrial, creative, and social living. These activities are planned as part of the treatment program. Trained occupational therapists and Red Cross recreators evaluate the patient's abilities and interests and plan and direct activities which will help him to follow his natural tendency to grow toward maturity. The effectiveness of these activities depends to a great extent upon support and cooperation from the other members of the psychiatric team, particularly the specialist. The patient's desire to participate is often aroused by the specialist who has a sincere, enthusiastic attitude regarding the value of therapeutic activities.

75. Types of Therapeutic Activities

Therapeutic activities are difficult to categorize because many of them are considered vocational for some patients and recreational for others.

a. Arts and crafts are therapeutic for many patients. The friendly, informal atmosphere while participating in these activities helps to change attitudes and promote relationships which aid in a patient's recovery. A patient can participate without feelings of competition and pressure. He has opportunities to create and produce something tangible. This helps him gain self-confidence and a feeling of personal achievement. Activities are utilized such as painting, sketching, ceramics, weaving, leatherwork, metalwork, woodwork, plastics, modeling, toymaking, jewelry, sewing, knitting, and needlework.

b. The term "recreational" can be applied to any activity which is a change from the patient's usual routine and which revives his interest and helps him feel refreshed. Activities which are usually considered recreational are reading; watching television and motion pictures; listening to the radio and recorded music; helping plan and prepare for parties, picnics, celebrations, and programs; attending these functions as well as variety shows, concerts, plays, ball games, and other recreational events on and off the post; singing, dancing, acting, playing musical instruments, and taking part in programs; participating in special activities such as stamp collecting, photography, nature lore, designing, literary groups, and forums; participating in sports such as swim-

ming, basketball, and football; and playing bridge, pinochle, checkers, and other games.

c. Educational activities can be an important part of the treatment program for a psychiatric patient. The time spent in the hospital should be a worthwhile learning experience. Although a patient gains some knowledge from all activities, carefully selected courses help to prepare him to live more successfully when he returns to military or civilian life.

d. The work therapy program under the administrative supervision of an occupational therapist may be beneficial for the psychiatric patient. It gives him realistic experience and an opportunity to be responsible for his actions while immediate psychiatric guidance is available. A work assignment is selected for a patient according to his aptitude and preference. He may be assigned to a job in the cafeteria, in the greenhouse, in the motor maintenance shop, or elsewhere in the hospital or on the post.

76. Role of the Specialist in Therapeutic Activities

The specialist should recognize the value of therapeutic activities and through his attitude stimulate patients to desire to participate. He escorts the closed ward patients to and from activities. If the occupational therapist or recreator asks him to participate in an activity, he does so as directed. During an activity he observes the patients' reactions and behavior and returns any patient who becomes upset to the ward.

Section IV. PHYSICAL CARE

77. General

a. Maintaining a healthy, clean body and a good personal appearance is an important part of the psychiatric patient's life on a hospital ward. Throughout the day he follows physical care routines which represent normal, healthful patterns of living. These routines are established locally and vary from one hospital to another. With interest and encouragement from the personnel and adequate bathroom facilities, some patients are able to care for themselves. Other patients who have such symptoms as apathy, depression, elation, withdrawal, or confusion require much assistance with their physical care.

b. The specialist supervises the patients during the physical care routines and gives them whatever assistance they need. Through his attitude and conversation with the patients he makes them feel more worthwhile and confident of themselves and the hospital staff. By encouraging the patients to assume more and more responsibility for their own physical care, he helps them take

one of the major steps toward becoming self-sufficient persons. Through his own personal hygiene, appearance, and behavior he represents to the patients what is "normal" and serves as a guide for them to follow.

78. Special Aspects of Physical Care

a. Physical Disease and Injury. When a patient complains of pain or injury, the specialist investigates and reports the complaint. Many psychiatric patients, however, never complain of physical discomfort. The specialist is, therefore, continually on the alert for possible signs and symptoms of physical disease and injury. He is aware of the fact that a patient may respond to physical discomfort by becoming depressed, anxious, or listless. He recognizes sleeplessness, refusal to eat, and objection to participating in activities as possible signs of physical discomfort. While supervising the patient's bath, he looks for rashes, cuts, bruises, or swollen areas. He checks for changes in the patient's weight and for irregularity of bowel movements. The specialist reports all signs and symptoms of physical disease or injury to the nurse immediately. He takes and records the patient's temperature, pulse, and respiration as instructed, using procedures described in TM 8–230.

b. Oral Hygiene. Cleanliness of the mouth and teeth not only helps to prevent tooth decay but also makes the patient feel better. The specialist makes certain that each patient has an opportunity to brush his teeth in the morning and evening and gives him the guidance and assistance he may need. Any time the specialist has reason to believe that the patient may have a sore mouth, he checks and reports any symptoms to the nurse immediately.

c. Showering. The specialist prepares the shower room by having clean towels and clothing available and by adjusting the temperature and flow of water to prevent scalding. He supervises the patients while showering and assists those who need help.

d. Shaving. The specialist encourages patients to shave themselves but never allows them to do so without supervision. He shaves the patients who are too ill to shave themselves.

e. Haircuts. Arrangements are made for a barber to come to the ward at a scheduled time, usually each week. A specialist remains in the room to be responsible for the equipment and to direct the sequence of the activity.

f. Shampoos. In order for patients to have clean healthy scalps, their hair needs shampooing at least once a week. Patients usually shampoo their own hair while they are showering. Some patients,

however, need assistance. For these patients, a special time for shampoo is set aside each week.

g. Nail Care. Nail files, scissors, and clippers are made available to patients when their fingernails or toenails need grooming. The specialist remains with them while they are using the nail care instruments, as they are potentially dangerous. For the patients who are unable to care for their own nails, a special time each week is set aside to assist them.

h. Elimination. Many psychiatric patients require the attention of the specialist to insure proper elimination. Although most patients tell the specialist when they are having difficulty with bowel or bladder elimination, the patient who is depressed, elated, confused, or preoccupied frequently does not report his difficulty. The specialist, therefore, checks to determine whether the patient's bowel functions are regular and adequate and to insure that his bladder does not become distended. He reports all symptoms to the nurse. The use of enemas and laxatives, in general, is discouraged. Good elimination is promoted by providing adequate fluids, proper diet, and physical exercise.

i. Incontinence. Because of his emotional illness the psychiatric patient may be unable to control his bowel or bladder functions. He may soil himself because he feels helpless, worthless, hopeless, resentful, or angry. Since this behavior is an expression of a need and has meaning for the patient, the specialist accepts incontinence without criticizing him in any way or showing any indication of disgust. The specialist immediately helps the patient who soils himself to take a shower and put on clean clothes. The specialist then encourages him to take part in some social, recreational, physical, or occupational activity.

j. Sleep and Rest.

(1) Many psychiatric patients have difficulty sleeping. Fear and anxiety are often the causes of sleeplessness. The patient may be afraid of other patients or treatment; he may fear that he will never get well or that he may die. He may be worried about his family or financial matters. He may have delusions or hallucinations. His sleeping difficulty may be caused by hunger, coughing, indigestion, or other physical discomforts.

(2) Adequate sleep and rest are essential to the patient's recovery. Helping the patient get adequate sleep and rest not only entails bedtime care but proper nursing care throughout the day and night. Seldom is it desirable to permit a patient to sit or lie on his bed listless and unoccupied during the day. A patient sleeps better at night

when he participates in activities during the day. Participation gets him physically tired enough to sleep and helps him release anxiety and tension which otherwise keep him awake.

(3) Getting the patient to bed calmly makes it easier for him to go to sleep. The specialist plans for each patient to have plenty of time to prepare for bed, to have clean and comfortably fitting pajamas, and to have an opportunity to wash his face and hands and to brush his teeth. The specialist regulates the temperature, ventilation, and lighting in the ward for sleeping comfort. If he observes that a patient appears frightened, tense, or depressed, he gives him extra attention and reassurance. If this does not help the patient relax and go to sleep, he consults the nurse.

(4) The specialist observes the patients throughout the night; and at irregular intervals of approximately thirty minutes he checks each patient for sleeplessness, restlessness, and talking or moaning in sleep. To avoid disturbing the patients, he directs his flashlight toward the ceiling. He must be alert to patients who get out of bed for any reason and must know where they go and what they do. The specialist records the nature of each patient's sleep, what the patient did if he was awake, and any interaction that occurred.

Section V. PROPER NUTRITION

79. General

Although a well-balanced diet is essential to health, psychiatric patients may refuse food or eat reluctantly. Food has deep psychological meanings which may be especially significant to mentally ill patients. Past experiences can influence a patient's attitude toward both food and the person offering it. For example, feeding experiences in infancy are closely associated with mother love, security, and acceptance or the lack of these. If feeding experiences are traumatic, they can cause eating problems in later life, particularly during periods of mental illness.

80. Refusal of Food

Patients refuse food for different reasons. Every effort is made to discover patients' individual problems in relation to food. The approach for getting each patient to eat is based on his particular reason for refusing the food. Some of the motives and possible approaches are stated as follows:

a. Dislike of Certain Foods. The menu contains foods of sufficient variety to enable the patient to have a balanced diet of foods that he likes.

b. Religious Reason. The patient is not expected to eat food which is against his religious belief. If necessary, arrangement is made for a special diet.

c. Allergy. The patient is guided in the selection of his foods in order to avoid those to which he is allergic.

d. Poor Teeth. The patient is given proper dental care and balanced diet of foods which he is able to chew.

e. Physical Illness. The patient may have pain, fever, nausea, or diarrhea which causes loss of appetite. He is given proper medical treatment and possibly a light diet of liquids.

f. Delirium. If the patient has clear intervals and will eat during these period, he is served food and is spoon-fed, if necessary; otherwise nourishment is given as prescribed by the physician.

g. Delusions. The patient may be unable to eat because of delusions. For example, he may feel that the food has been poisoned. Since the patient with delusions does not generally trust people, it is necessary to gain his confidence first in order to convince him that his food is not poisoned. Tasting the food sometimes helps convince the patient that it is all right.

h. Hallucinations. The patient may hear voices telling him not to eat. Since the patient tends to hallucinate more when he is alone and idle, he is engaged in conversation which requires his active response.

i. Depression. The depressed patient may lack the energy and initiative necessary to eat. The depressed patient who has strong suicidal drives may try to starve himself. In either case the patient is provided appetizing food in a pleasant environment and is encouraged to eat.

j. Preoccupation. The patient may be so absorbed in his thoughts that he does not eat. Engaging him in conversation that focuses his attention on eating may be a successful approach.

k. Indecision. The patient may be unable to decide which of the foods on his plate he should eat first. The order in which he should eat his foods is suggested to him. If this does not start his eating, it may be necessary to serve him only one food at a time until he is better able to make the decision.

l. Overactivity. The patient may be too busy to eat. He is served appetizing food in small quantity at frequent intervals.

m. Anxiety. The patient may be so anxious that he is unable to eat. Effort is made to determine the cause of the anxiety and to minimize it.

n. Attention Seeking. The patient may refuse food in an attempt to get special attention. The patient's refusal is accepted in a manner to avoid his gaining attention in this way. He is given the special attention he needs in other ways, thereby decreasing his need to refuse food.

o. Destructiveness. A patient who is impulsive may throw food, break dishes, and disrupt the meal for other patients. His food is served on the ward where there is a minimum of stimulation.

81. Socializing Factor in Eating

a. Eating together is one of the most basic social activities. When at all possible, arrangements are made, therefore, for psychiatric patients in the hospital to eat together. In many hospitals the staff has found it beneficial to eat with the patients. The patients are served their food by dietary personnel in a dining room which has been made as attractive as possible. Only the patients who are too disturbed to eat in the dining room are served their food on the ward.

b. Food is also served other than at mealtime to promote socialization among patients and personnel. Light refreshments are frequently served during the morning, afternoon, and evening social activity.

82. Role of the Specialist in Feeding Patients

a. The specialist gives the patients whatever assistance they need to be prepared for their meals at the designated time. He may escort patients to the dining room, or he may serve food on the ward to the patients who are unable to go to the dining room. He observes the patients' eating habits and nutritional intake and encourages them to eat a well-balanced diet. He maintains a pleasant environment conducive to eating. He is aware of the hazardous nature of silverware and accounts for it before the patients leave the table. He reports the eating habits and nutritional intake of each patient as well as any unusual behavior.

b. The specialist spoon-feeds the patient who is too ill to feed himself or who refuses to eat. In preparing the patient to eat, the specialist always explains what is to take place. If the patient is able to get out of bed, he is seated in a chair; otherwise he is placed in a comfortable sitting position in bed. The specialist feeds the patient with a spoon and gives him ample time to chew and swallow each bite of food before he offers him another. He never forces food into the patient's mouth. If the patient steadfastly refuses to open his mouth, he should ask the nurse for guidance.

Secton VI. CONTROL OF HAZARDS

83. General

For an environment to be therapeutic, it must be safe. Control of hazards contributes to the effectiveness of the other therapeutic aspects of the environment. All members of the team must appreciate the seriousness of protective policies and procedures and carry them out consistently. They must give the patient an honest explanation of the reason for the protective routines and restrictions placed upon him and convey through their attitudes that they are sincerely interested in his safety.

84. Role of Specialist in Controlling Hazards

Although the things considered hazards to psychiatric patients are somewhat the same in all hospitals, the ways in which they are controlled vary in each hospital. It is most important that the specialist become thoroughly familiar with the controls prescribed locally and carry them out faithfully at all times.

a. Management of Keys. The specialist is issued keys to all doors that are kept locked for the safety of patients. He is entrusted with the important responsibility of managing his keys properly. Carelessness on his part can cause the death of a patient. The specialist keeps his keys secure in his pocket when he is not using them, relocks doors each time he enters or exits, and unlocks doors for authorized personnel only. Any time that a key becomes jammed in a lock, he remains at the door and requests another member of the staff to call the locksmith. If he loses his keys, he reports the loss to the nurse immediately. To help alleviate the patients' sensitiveness to locked doors, the specialist uses his keys quietly and keeps them out of sight when not in use. He must follow the locally prescribed procedure for checking his keys out and in.

b. Control of Hazardous Articles.

(1) When a patient is admitted to a hospital, it is common practice not to allow the patient to take any personal articles which are potentially dangerous onto the ward. All articles such as nail files, clippers, tweezers, and cosmetics are labeled and stored for his use when he needs them. He is always supervised while using such articles, and they are accounted for after he finishes with them. The fact that the patient wears spectacles or dentures is recorded when he is admitted and made known to all members of the staff. A patient's spectacles, labeled with his name, are issued to him in the morning

and taken from him at bedtime. The specialist must be observant to notice at once when a patient is not wearing his spectacles. Ordinarily, most patients are permitted to wear their dentures day and night. Dentures are removed from stuporous or comatose patients and from patients before electrovulsive or insulin therapies. Any time dentures are removed, they are stored in covered opaque containers labeled with the patient's name.

(2) All clothing and linen are made as safe as possible for patients. Belts are either securely sewed to the wearing apparel or eliminated. Torn linen is never used on the ward, thus making it possible for the specialist to learn if any patient is tearing pieces from linen.

(3) If possible, items which patients use or to which they have access are made of safe materials. Drinking and cosmetic containers are made of plastic; mirrors are made of metal. Protective procedures are carefully followed when it is necessary for patients to use hazardous articles. Silverware is accounted for before patients leave the table. Patients are supervised while using occupational therapy equipment. A shadow board is frequently used to account for tools before patients leave the shop. When patients use such tools on the ward, each tool is accounted for. The hazards associated with smoking are controlled by observing the patient while he is smoking. If a patient has special permission to smoke in bed, the specialist stays with him until he finishes his cigarette and puts it out.

(4) Showering. The control of hazards associated with showering is discussed in paragraph 78*c*.

(5) After a medicine is dispensed by the nurse, the specialist may take it to the patient. To insure that the correct patient gets the medication, the specialist must know the patient by name before giving him the medication. He remains with the patient until he takes the medication and drinks at least three ounces of water to be sure that he swallows the medication and does not have the opportunity to accumulate it for a harmful dosage in the future. He returns any medication refused by a patient to the nurse and gives a verbal report of the patient's refusal.

(6) Insecticides, antiseptics, disinfectants, polish, and other cleaning solutions are stored in locked closets. Only the amount of solution to be used immediately is taken from the storage closet.

c. Recovery of Lost Articles. When the specialist discovers that an article is missing, he immediately notifies the nurse and checks the sign-out book, if one is maintained, to learn who had the article last and where it was used. If the missiong article is especially hazardous, all patients are supervised while a search is made. Logical places such as the garbage for silverware or the laundry for personal articles are searched first. If necessary, the ward is searched, after escorting the patients to the dayroom or an activity off the ward. If the article is not found, each patient is searched in as tactful a manner as possible when he is returned to the ward. Patients who are most likely to have the articles are returned and searched first.

d. Control of Hazards in the Physical Structure. Any time hazards which cannot be eliminated exist in the physical structure, the specialist supervises the patients closely when the activity requires them to be in the area of a hazard. For example, unguarded radiators, bathtubs, dumbwaiters, laundry chutes, exposed water pipes, slippery floors, and icy walks can be very hazardous to patients. When repairs are being made, the patients are restricted from the workmen's area. The workmen are instructed regarding the precautions they should take for the safety of patients, and the area is checked when the workmen complete the repairs.

e. Prevention and Control of Fire and Evacuation of Patients.

(1) Every member of the hospital staff reduces the possibility of a fire by observing and enforcing regulations which govern smoking; the use of oxygen, anesthesia, alcohol, acetone, and ether; storage of waste; and maintenance of equipment and building. In case a fire should occur, every member of the staff must know how to report a fire, the location of the fire equipment, the location of the key to the area where the equipment is kept, and how to use the equipment. When a fire occurs, the personnel's primary responsibility is to evacuate the patients and priority records.

(2) Most deaths that have occurred in burning buildings have been attributed to the lack of an evacuation plan or to panic. To prevent such unnecessary deaths, all personnel must be thoroughly familiar with the local evacuation plan, where the exits are located, and where keys to the exits are kept. When an evacuation order is given, each person must carry out his responsibilities in a calm, systematic manner. The specialist's role in the evacuation plan may be as follows:

(*a*) Closes doors leading to blaze area.
(*b*) Never uses elevators, dumbwaiters, or laundry chutes, as they create drafts.
(*c*) Checks all private rooms, removes any patients, and locks doors to rooms.
(*d*) Evacuates patients according to plan and accounts for each patient.
(*e*) Insures that sufficient glucose and necessary equipment accompany patients recovering from insulin therapy.
(*f*) Gives extra assistance to patients recovering from shock or sedation.
(*g*) Gives special attention to suicidal and escape patients.
(*h*) Evacuates physically ill patients by litter, if necessary.
(*i*) Preserves records, if possible.

Section VII. PREVENTION OF SUICIDE

85. Factors in Suicide

a. A patient who wants to commit suicide has become overwhelmed by problems he cannot face and solve. He feels powerless to find a solution to his intolerable situation. He feels that no one really cares about his plight. He may be suspicious of the people who try to help him. To the patient, suicide seems the only way out.

b. Actually, it is not the patient's problems that make his life seem so intolerable but the way he feels about them. For example, blindness may be a reason for suicide for one person and a motivating factor for another person to become a great composer. Many factors influence a patient's decision to end his own life. Loneliness seems to be a primary one. The patient who does not identify himself with some group such as a family, church, or community seems to be more susceptible to suicidal thoughts. The psychiatric patient who is also physically ill may resort to suicide, particularly if he is in much pain, his prognosis is poor, he feels that he is a burden to others, or he is severely disfigured. Loss of a loved one, accompanied by feeling of guilt and depression or inability to transfer affections to someone else, may be an influencing factor in suicide. Loss of prestige or decline in social position may be a contributing factor.

c. A patient's psychiatric condition may cause him to commit suicide. The patient who is recovering from an attack of depression may feel unable to cope with the stress and strain of living and discouraged to the point of taking his own life. The patient

who recognizes the symptoms of another oncoming attack of depression may feel he cannot go through the painful experience again. A patient may have delusions or hallucinations which threaten him or command him to kill himself. A confused, disoriented patient suffering from an organic brain disorder or from alcohol or drug intoxication is also likely to commit suicide, especially at night when he tends to be most confused.

d. It is also possible for a patient to have an unconscious motive which drives him to commit suicide. For example, the patient who, for some reason, cannot direct his aggression against a person whom he hates may turn these feelings of hatred and aggression against himself. When he kills himself, he is symbolically killing the hated person. A patient may kill himself for spite or revenge. He may feel that by destroying himself he can make certain persons grieve and repent for real or fancied wrongs that they have done him, or he may feel that only death is severe enough punishment for his real or fancied wrongs. Not every patient who attempts suicide plans for the results to be self-destruction. He may see a suicidal attempt as the only way to get people to understand exactly how terrible he feels and to do something for him. He intends for someone to rescue him in time to prevent death.

86. Planned and Unplanned Suicides

One patient may plan suicide for weeks or months; another patient may act on impulse. The patient who plans suicide learns ward routine, practices of the ward personnel, and times when there is less supervision or more noise and confusion on the ward. He schemes to obtain and hide necessary articles. He carefully works out every step in the plan. Furthermore, he may have two or more plans in case one fails. The patient who commits suicide impulsively may act in response to bizarre ideas or voices that he hears. He commits suicide when an opportunity arises. Such an opportunity may be presented by careless personnel who are not alert to hazards or who inadequately observe and supervise patients' activities.

87. Suicidal Classification of Patients

a. Potentially Suicidal. Usually all psychiatric patients are considered to be potentialy suicidal because their behavior cannot be accurately predicted.

b. Suicidal Risk. Every new admission is classified as a suicidal risk for 48 to 72 hours because the personnel do not have a knowledge of his behavior. Otherwise, this classification is given to patients by the psychiatrist.

c. Actively Suicidal. Patients in this classification are those who are known to be actively contemplating or planning suicide. These patients are given constant supervision 24 hours a day. One specialist may be assigned solely to the care of one actively suicidal patient.

88. Role of the Specialist in Preventing Suicide

a. Recognized Suicidal Intentions.

(1) Being in constant contact with patients, the specialist has more opportunities to observe them for suicidal intentions than any other member of the psychiatric team. His knowledge of the patients enables him to recognize changes in behavior as possible indications of suicidal intention and to observe suicidal implication in statements made by patients. For example, a patient's becoming more alert and cheerful would seem to indicate improvement; but to the specialist this behavior should suggest that the patient may feel relieved for having made the decision to end his intolerable problems by suicide. Another example could be a patient who has previously been outwardly disturbed but who becomes calm and controlled only because he has turned his aggression inward upon himself.

(2) The specialist is alert at all times for any possible indication of suicidal intention. Such an intention may be revealed by observing that a patient has special interest in items which could be used to commit suicide. He may try to take and conceal such items as silverware or occupational therapy tools. A patient with suicidal thoughts may be unable to sleep or refuse to eat. He may actually talk about committing suicide. The specialist takes any suicidal remark seriously. The belief that people who talk about committing suicide will never do so is a serious fallacy. The threat of suicide as an attention-gaining device is also taken seriously because accidents do happen. The specialist shows interest in the patient and helps him meet his need for attention in a constructive way. The specialist reports carefully all behavior or statements which indicate that a patient may be contemplating suicide.

(3) Suicidal tendencies in a patient are also revealed and reported by other members of the psychiatric team. The social worker may learn from a patient's family or friends that he has made suicidal attempts. This is an

indication that he may attempt suicide again. Psychological testing of a patient may reveal suicidal tendencies. The psychiatrist may discover overt or latent suicidal drives. A patient's selection of subjects or colors for his paintings or drawings may reveal morbid or suicidal thoughts.

b. Supervising Suicidal Patients. As long as a patient is classified as a suicidal risk or as actively suicidal, he is under constant supervision of the specialist. Since it is impossible to observe a patient constantly without his knowing it, the specialist answers any questions that the patient may ask about the surveillance truthfully. In most cases the psychiatrist or nurse will have already explained to the patient why the specialist is staying with him, and the patient will be asking merely to confirm what he has already been told. If the patient does not know or has not been told, the specialist explains the protective procedure to him.

c. Lessening the Patient's Need to Commit Suicide. By creating an environment in which the patient can experience relationships that made him feel more secure, acceptable, and worthwhile, the specialist lessens the patient's need to commit suicide. The specialist guides the patient's interest and efforts into constructive channels instead of watching him solely to prevent a suicidal act. This may mean getting the suicidal patient to participate in an activity where he can experience success and relationships with other people. For the less responsive suicidal patient, it may mean encouraging him to share his feelings and giving him the emotional warmth and personal care which will make him feel that someone is genuinely interested in him as a person.

d. Maintaining a Safe Physical Environment. A safe physical environment for the suicidal patient is one which not only protects him from accidental injury but also minimizes his opportunity for suicide. Many articles necessary for his care and comfort can be converted into suicidal instruments. Many uncontrollable conditions in the physical structure can be used as a means to suicide. Maintaining an environment which is safe for the suicidal patient makes it necessary, therefore, to place certain restrictions upon the patients and to follow specific routines in order to control hazards (par. 84).

89. Emergency Care of Intentional or Accidental Injuries

If a patient succeeds in making a suicidal attempt or if he is accidentally injured, immediate care may mean the difference of life or death, rapid recovery or long hospitalization, and tempor-

ary or permanent disability. The specialist provides emergency care as stated under the following situations:

a. Hanging.

(1) Lifts body to release pressure on the neck.
(2) Calls for help and asks that the nurse be notified.
(3) Cuts the patient down when another person arrives to support the body and prevent further injury.
(4) Gives artificial respiration until a physician arrives.

b. Drowning.

(1) Removes patient from the water.
(2) Insures that the patient's air passage is clear.
(3) Gives artificial respiration.
(4) Calls for assistance and asks that the nurse be notified.

c. Poisioning.

(1) Notifies the nurse immediately.
(2) Tries to learn what the patient has taken.

d. Laceration of Artery or Vein.

(1) Applies pressure with clean dressing.
(2) Notifies the nurse.
(3) Attempts to establish a clear airway in case of throat laceration.

e. Burning by Fire or Scalding.

(1) Never touches the burned area.
(2) Notifies the nurse.
(3) Keeps patient with an extensive burn flat and warm.

f. Fractures.

(1) Keeps patient flat and warm.
(2) Does not move injured part.
(3) Notifies ward nurse.
(4) Controls bleeding, if necessary.

g. Head Injuries.

(1) Keeps patient quiet, flat, and warm.
(2) Notifies the nurse immediately.

Section VIII. PREVENTION OF ESCAPE

90. General

Psychiatric patients try to escape from the hospital for various reasons. A patient may fail to understand the nature of his illness and feel that he is being held without cause or that he would be better at home. He may think the personnel are uninterested in helping him, poorly trained, or unkind. He may want to leave

the hospital because of family or financial problems. An addicted patient may want alcohol or drugs. The suicidal or homicidal patient may try to escape in order to carry out his destructive impulses. Others may attempt an escape in response to delusions, hallucinations, or frustration. A confused patient may leave the hospital grounds unintentionally. For the safety of these patients certain protective measures are necessary. Since the specialist is in closer association with the patients than any other team member, he is responsible for preventing their escape.

91. Role of the Specialist Regarding Escape

a. Preventing Escape. The infrequency of escape attempts from hospitals in the past is attributed to alert, conscientious specialists. The specialist develops with the patient a mutual feeling of trust and lessens the patient's need to escape by making him feel accepted, confident about the treatment, and hopeful of recovery. He is always aware of what the patient is doing and is observant of any indication of a plan to escape. For example, he may observe that a patient is making keys from a coat hanger or silverware. He reports any unusual behavior which occurs on or off the ward to the nurse. He relocks each door he enters or exits and insures that no condition which might invite escape prevails. He never allows an unauthorized person to enter the ward nor lets a person whom he does not know leave the ward unless he has been instructed to do so. Before he escorts patients to activities off the ward, he prepares a list of their names. He identifies each patient with his name on the list before he leaves the ward, at frequent intervals while off the ward, and when returning to the ward. He observes patients closely to insure that no patient leaves the group and returns them directly to the ward at the designated time. When he escorts a patient to a clinic appointment, he signs the patient out, indicating time and destination. He escorts the patient directly to and from the clinic, never permitting any side trips along the way. To give the patient a feeling of support and protection in the unfamiliar clinic situation, the specialist remains with him all the time. Under such conditions, a patient seldom becomes upset or uncooperative. When this does happen, the specialist telephones the nurse for instructions.

b. Recovering Patient Who Escapes. Any time that a patient is successful in escaping from a group, one specialist follows the patient; and the other specialists remain with the group. The specialist who is group leader notifies the nurse to send assistance and gives her an accurate description of the patient. When a specialist is escorting only the one patient who escapes, he fol-

lows him and gets help en route. If possible, he notifies the nurse to send assistance and gives an accurate description of the patient.

c. Caring for Patient Returned to the Ward. The specialist maintains a pleasant, noncritical attitude toward the patient. He notifies the nurse that the patient has been returned and carries out any special orders that she may give. Ordinarily, he assists the patient in taking a bath and examines him for injury or concealed articles. He gives the patient a cold or hot drink, depending upon the weather, and gets him interested in an activity. If the patient has been missing over 24 hours, he treats him as a new admission.

Section IX. PREVENTION AND MANAGEMENT OF ASSAULTIVE BEHAVIOR

92. General

Assaultive behavior describes action carried out in a forceful way. It is prompted by fear and frustration which arouse hostile feelings. It may be a reaction to delusions or hallucinations. It may be a response to threatened self-esteem, resulting from confinement to the hospital and dependency upon hospital personnel. A patient may direct his aggressive acts toward persons or objects in the environment. He may strike at a member of the hospital staff or another patient because he misidentifies him or misinterprets his intentions. Unless the patient finds outward expression of his hostility, he may turn it upon himself. The extent to which assaultive behavior is prevented or effectively managed depends upon the personnel's abilities to maintain a calm, understanding, accepting approach to the patient and to find constructive outlets for the patient's feelings and energy.

93. Role of the Specialist in Preventing and Managing Assaultive Behavior

a. The specialist understands that his own competence, self-assurance, and tactful handling of the patient are extremely important in preventing assaultive behavior. He realizes that any fear or expectation of assaultive behavior on his part is easily communicated to the patient, making him feel even more frightened and insecure and, in turn, more assaultive. He also realizes that some particular act of his may cause the patient to become upset. The specialist, therefore, searches his own behavior and feelings for anything which may irritate the patient or make him feel frightened and insecure.

b. Through close association with the patients, the specialist knows which patients are easily disturbed, what situations seem to upset them, the particular ways in which they react when they start becoming upset, and their reactions to any efforts made to calm them in the past. He also knows which patients do not get along well together. He strives to prevent situations which provoke the patients' anger. He may try to change a patient's course of behavior by diverting his attention, by introducing something of interest to him, or by giving him the attention he needs to make him feel appreciated and secure. To reduce a patient's need to act out and to obtain a better understanding of him, the specialist may encourage him to talk about his angry feelings and the reason for his anger. He may guide the patient into some physical activity which enables him to use his energy in releasing these angry feelings. The specialist may get other personnel to join him, as the presence of several persons sometimes quiets an excited patient. If one approach fails, he tries another.

c. Regardless of how competent, understanding, tactful, and calm the specialist is in caring for patients, he may not be able to predict and prevent all assaultive behavior. He must also be able to manage assaultive behavior.

(1) A patient's assaultive act may be in response to delusions or hallucinations. In dealing with this behavior, the specialist must acknowledge the patient's right to his beliefs, try to understand how things must appear from his point of view, and treat him in a way which makes him feel more secure and protected. A patient may suddenly direct hostile feelings which he has toward his father, for example, on the specialist. Another patient may act in a threatening manner in an attempt to provoke the specialist into using force with him because he feels the need to be punished. Assaultive behavior may be a lifelong pattern used by a particular patient when he desperately needs attention. The specialist should understand that avoiding or rejecting a patient or responding to him with hostility would in no way be therapeutic. Avoiding the patient would reinforce his conception of himself as a dangerous person and make him continue his hostile acts. Rejecting him would merely intensify his belief that he is alone in a hostile world. Permitting a patient to succeed in provoking a scuffle would reinforce the unacceptable way he has of dealing with other people. The specialist must realize that a patient does not strike out because he wants to hurt someone but because he is so terribly

frightened and that a patient who is made to feel secure and protected has no need to fight. He must further realize that a patient cannot feel secure and protected unless he sees the specialist as a person who is not afraid to control him when he is unable to control himself.

(2) In dealing with assaultive behavior, quick action is essential. He may find it necessary to get assistance from several members of the staff to restrain the patient physically to let him know that they are not going to permit him to harm himself or anyone else. Personnel in numbers are always used in preference to mechanical restraint because mechanical restraint gives the patient another reason to be fearful, tense, angry, and suspicious. Only under the unusual circumstance of not having sufficient personnel available to handle the situation constructively is the use of mechanical restraint justifiable. Even then it should be used only as a temporary means of controlling the patient's behavior. (Leather restraints, the most acceptable form of mechanical restraint, are discussed in par. 146.) Regardless of the method used to restrain the patient, the specialist should make it as easy as possible for the patient to calm down without feeling that he has lost face in any way. When the disturbance subsides, the specialist lets the patient know that he has no ill-feeling toward him, that he respects his need to act out, and that he still accepts him as a worthwhile person. He encourages him to become interested in an activity which will enhance his feelings of security, worth, and acceptance.

CHAPTER 6
PSYCHIATRIC DISORDERS

94. Development of Psychiatric Disorders

Although psychiatric disorders, like physical illnesses, have causes, no specific factors, condition, or experience causes a person to develop a psychiatric disorder. All of the factors involved in the development and functioning of the personality and all of life experiences enter into the development of a psychiatric disorder. As discussed in Chapter 2, "Personality Growth and Development," the personality develops through the interactions of heredity, environment, and learning. Because of the ways in which some individuals have learned to think, feel, and act, they experience many difficulties in adjusting to life situations. They may be able to manage their lives adequately until they are confronted with an environment in which there are situations that severely tax their adjustive capabilities. For example, a person who has managed to cope with situations in an earlier environment may not be able to tolerate the stresses which he experiences in college, marriage, military service, or disaster. Behavior is the reaction of one's total personality in a situation. The individual who is unable to work out realistic, acceptable ways of adjusting to life situations develops symptoms which will help relieve his painful feelings such as anxiety and guilt or resentment and which he can use to escape the demands placed upon him by other people. As painful as these symptoms frequently are, they are not as painful as the emotions which the individual experiences from the unresolved conflicts and frustrations in his life.

95. General Classification and Characteristics of Psychiatric Disorders

No two patient's symptoms and behavior are exactly alike, as no two individuals have identical personalities. They not only have had different experiences in life but also have learned to respond to similar situations in different ways. For these reasons, it is difficult to classify psychiatric disorders; however, they are classified according to clinical findings and characteristics of patients in order to simplify communication in treatment and care. Although the psychiatric specialist's responsibility is

to provide nursing care which meets the needs of the individual patient regardless of the classification of his illness, the specialist should know the following general classifications of psychiatric disorders in order that he may understand the patient's clinical records and communicate more effectively with other members of the psychiatric team. (For a detailed classification of neuropsychiatric disorders, see app. II).

a. Psychotic Disorders. These disorders are characterized by varying degrees of personality disorganizations and failure to evaluate correctly or perceive external reality. Individuals with such disorders fail to utilize their ability to relate themselves effectively to other people and to their work. The two most common reactions of psychotic disorders are schizophrenic and affective.

(1) *Schizophrenic reactions.* The word "schizophrenia" is taken from two Greek words, one meaning "split" and the other meaning "mind." The word indicates a lack of harmony in thinking, feeling, and behaving. An individual with a schizophrenic reaction generally manifests gradual changes in personality, such as losing interest in his family, friends, and work. As the disorder progresses, he withdraws from reality, his thinking becomes disconnected and illogical; he manifests fanciful and absurd delusions which have meaning only to himself. He may become resistive, mute, and negativistic; he may develop bizarre mannerisms and a peculiar gait; he may exhibit impulsive outbursts of silly laughter or combativeness. Although most patients recover; some have a tendency toward deterioration.

(2) *Affective reactions.* An affective reaction is characterized primarily by a severe mood disorder which results in a disturbance of the person's thoughts and behavior. The person may appear either extremely elated or depressed. At times he may show cyclic alternation of moods.

b. Neurotic Disorders (Synonymous with the term *psychoneurotic disorders,* par 2, app. II). These disorders—relatively mild personality disturbances such as feelings of inadequacy, anger, and failure— arise from an effort to deal with specific psychological problems and are brought on by stressful situations. The chief characteristic or symptom is anxiety. The individual may directly feel the anxiety and express his feelings as apprehension or worry, or he may unconsciously try to control the anxiety by various mental mechanisms such as conversion and displacement.

c. Psychosomatic Disorders. (Synonymous with the term *somatization reaction* of psychoneurotic disorders, par. 2*g*, app. II). These disorders comprise a group of reactions in which the individual's emotions such as anger and anxiety are expressed through the body organs controlled by the involuntary nervous system. Symptoms such as stomach ache, headache, and difficulty in breathing for which there are no organic causes are expressions of the individual's emotional state. It is postulated that if this state persists for an extended period of time, it will lead to actual tissue changes such as stomach ulcer, migraine headaches, and asthma.

d. Character and Behavior Disorders. These disorders are characterized by a developmental defect in personality structure with relatively little manifestation of overt anxiety or distress. They are manifested by lifelong patterns of behavior in adjusting to life situations. During periods of stress the behavioral patterns may become exaggerated and disabling.

e. Organic Behavior Disorders. These are personality disorders which are due to impaired brain function and which may be either psychotic or nonpsychotic. They are separated into acute and chronic, depending on whether the brain damage is temporary or permanent. They are characterized by certain symptoms common to all brain damage such as (1) impairment of orientation, (2) impairment of intellectual functions—loss of recent memory, poor judgement, et cetera, and (3) marked lability of affect.

f. Transient Personality Disorders Due to Acute or Special Stress. Under conditions of great stress a person may use abnormal patterns of behavior to express fear or flight reactions. These reactions may be distinguished from those of nuerosis and psychosis by the findings: The individual has no previous history of abnormal reactions, and his reactions are temporary.

CHAPTER 7
NURSING CARE OF PSYCHIATRIC PATIENTS

Section I. NEW PATIENT

96. General

a. Nursing care begins with the admission of the patient to the hospital. At no other time is the patient more in need of guidance, empathy, and reassurance. He may have many fears about being admitted to the neuropsychiatric service. He may be resentful or confused about the reason for his admission. He may be extremely antagonistic or withdrawn and unresponsive. Ordinarily, he has deep feelings of insecurity. The care which the patient receives when he enters the hospital greatly influences his feelings about the hosptial, the personnel, and the treatment which he receives later.

b. The patient may be admitted from duty, his quarters, or another hospital. The patient usually enters the hospital through the admission office where he is asked to turn over to the Patient Trust Fund any valuables or money. Ordinarily, at this time hospital clothing is issued to him, and his own clothing and other personal items are turned in for storage in the clothing room until his discharge from the hospital. Copies of the records describing his valuables and personal property are delivered to the neuropsychiatric service where they are placed in safekeeping for the patient. Sometimes the psychiatric patient refuses to release his valuables and personal property. Moreover, he may be brought directly to the ward because he is too ill to be taken through the admission office. In such cases arrangements are made by the neuropsychiatric service for turning in his valuables and personal property (par. 100).

97. Therapeutic Admission Care

Admission care is designed to provide the patient experiences which strengthen his self-esteem, help him to feel safe, and build his feeling of confidence in the hospital personnel. Much of the responsibility for providing such experiences rests with the specialist.

a. Acceptance of the New Patient. Frequently, the specialist is the first person to talk with the patient when he arrives on the

ward. The specialist's first responsibility after the patient arrives is to make him feel as secure as possible. He greets the patient by his name and introduces himself. If he does not know the patient's name before he arrives, he introduces himself, asks the patient his name, and greets him by it. He extends a welcome to the patient, letting him know that the personnel in the hospital are interested in helping him. He then escorts the patient to the nurse's office and introduces him to the nurse and any person present. These common courtesies help the patient to feel that people are interested in him as an individual and to overcome some of his fearfulness. After the nurse contacts the psychiatrist for any special orders, the admission procedures are continued. If the patient is very disturbed or is admitted by litter, the psychiatrist will want to examine him immediately; otherwise he may prefer that the general admission routines be completed before the examination.

b. General Admission Routines. The general admission routines include removing and insuring the safekeeping of any valuables and clothing in the patient's possession (par. 100); taking and recording the patient's temperature, pulse, respiration, blood pressure, age, height, and weight; and arranging for the patient to shower or, if necessary, to be given a bed bath. (For explanation of these basic nursing care procedures, see TM 8–230.) Before the specialist starts each routine, he explains to the patient what he plans to do and why. During the shower or bath he checks for any marks, scars, rash, and injuries and reports any abnormalities to the nurse. After the patient is dressed in hospital clothing, the specialist shows him his bed and introduces him to other personnel and patients on the ward.

c. Orientation of the Patient. Orientation includes explanations of ward routines, rules, and procedures, such as those governing mealtimes, bathing, shaving, mail, visitors, and telephone calls. The specialist is careful to avoid overwhelming the patient with too much information at any one time. The open ward patient is also given a folder of regulations containing such information as the time that the psychiatrist makes ward rounds, passes and leave policies, procedure for signing out and in, activities which the patient is to attend, care of valuables and money, and responsibilities for keeping appointments, reading bulletin board, and maintaining cleanliness of ward. The specialist helps the patient to understand these regulations and to accept them without resentment.

98. Observing and Recording

Careful observation of the patient at the time of admission to the hospital and accurate recording of facts are important aids in planning treatment and care for the patient. The following questions will guide the specialist in observing and recording the most pertinent facts about the patient's physical appearance and symptoms, behavior, and conservation:

a. Physical Appearance and Symptoms.

(1) Is the patient walking, in a wheel chair, or on a litter when he arrives?
(2) Are his clothes, shoes, hair, and nails clean or dirty?
(3) Is his facial expression sad, cheerful, strained, or otherwise?
(4) Does he wear glasses or dentures?
(5) What is his temperature? What are the rates of his pulse, respiration, and blood pressure?
(6) What are his age, height, and weight?
(7) Are there any marks, tattoos, scars, rashes, or injuries on his body?
(8) Does he have any deformities?
(9) Does he have tremors?
(10) Does he have a cough? Does he have diarrhea? Has he vomited?
(11) Does he appear to be well-nourished?

b. Behavior.

(1) What is his response to admission care? For example, is he cooperative or uncooperative?
(2) What are his emotional reactions? For example, is he hostile, friendly, or withdrawn?
(3) Are his movements fast, slow, smooth, jerky, clumsy, graceful, determined, or uncoordinated?

c. Conversation.

(1) Is his rate of speech average, fast, or slow?
(2) Is his tone of voice soft, harsh, loud, or monotonous?
(3) Does he answer questions? If so, does he answer them freely or reluctantly? Does he initiate conservation? If so, about what?
(4) Does he ask questions? If so, about what?
(5) Does he complain of any ailments? If so, what?

99. New Patient by Transfer

To transfer a patient means to move him from one ward to another within the same hospital. The patient's response to being

transferred to the psychiatric ward and his emotional reactions are no different from those which a patient may have when he is admitted to the psychiatric ward at the time he enters the hospital. A patient moved from the open ward to the closed ward may react in the same way. Also, the patient going to the open ward from the closed ward may feel insecure, uncertain, and fearful because he has become accustomed to considerable security and protection. The specialist's approach to the patient who is coming onto any psychiatric ward is one of kindness and helpfulness. His primary objective during the admission period is to strengthen the patient's self-esteem, make him feel more secure, build his trust in the hospital personnel, and help him become oriented to the ward routines, rules, and procedures.

100. Personal Property of the Patient

When a patient arrives on the psychiatric ward in his own clothing and with valuables or money and other personal items in his possession, arrangements are made for the officer with the appropriate delegated authority to accept and turn in these items to the Patient Trust Fund and the clothing room. This officer prepares the necessary deposit records which are signed by himself and the patient or disinterested witnesses if the patient is unable or unwilling to sign. The patient's copies of these records are placed in safekeeping on the neuropsychiatric service for the patient. This officer is also responsible for securing necessary signatures and maintaining records of withdrawals made by or for the patient while he is hospitalized.

a. Open Ward Patient. The patient who is admitted to the open ward may keep certain items such as identification cards, religious and sentimental articles, a limited amount of money, and other items which can be stored in his bedside stand. If the patient is placed in a work therapy program, he may also be allowed to keep uniforms and civilian clothing on the ward. The patient is responsible for the safekeeping of the clothing and articles.

b. Closed Ward Patient. The articles which the closed ward patient may keep on the ward are specified in local policy of the neuropsychiatric service. Ordinarily, he is permitted to retain items such as certain toilet supplies in plastic containers, toothbrush, comb, personal letters, and writing paper. All items which the patient is permitted to keep must be marked with his name. Other personal items may be stored for his use when he needs them. Depending upon hospital policy, the psychiatrist may permit the patient to purchase certain comfort items, in which case

the cost is charged against the money deposited in the patient's trust fund.

Section II. ANXIETY AS THE MOTIVATOR OF BEHAVIOR

101. General

Anxiety occupies an important place in relation to the state of mental health of the individual. The severity or intensity and duration of anxiety and the means used to relieve or avoid it are important determinants of behavior. The specialist, therefore, needs knowledge of its meaning, causes, expressions and effects and of the common defenses used to avoid or to get relief from it. With such knowledge he is better able to understand the exaggerated defenses which the patient uses to control or to get relief from anxiety when it becomes intolerable.

102. Definition

Anxiety is a specific unpleasant state of tension, usually associated with a feeling of apprehension, which indicates a threat or danger to the individual. Anxiety and fear are alike in several respects and are often used as if they were the same; however, there are differences which should be recognized. Fear refers to an actual, present danger that threatens from without. Also, fear is a temporary feeling, since usually the external danger is soon removed either by escape or conquest. The individual knows of what he is afraid; that is, he recognizes the feared object or event. When he is anxious, he does not know the source of the anxiety.

103. Causes of Anxiety

Anxiety arises from inner impulses which threaten to get out of control from frustrations, insecurity, and hostility. The most severe anxiety is aroused by threats to feelings of security, adequacy, and self-esteem. Anything that threatens the individual's self-structure or self-concept causes anxiety. Every person is subjected to threats or stresses of many varieties in his daily living from many sources: the environment, interpersonal relationships, physical condition, social and economic status, and others. When the individual is unable to adjust adequately to meet all of these threats, he feels anxiety.

104. Expressions of Anxiety

a. Anxiety is experienced both psychologically and physically. The psychological expression is the feeling of inner tension, apprehension, displeasure, and awareness that something is wrong.

Anxiety is expressed physically by rapid heartbeat and respirations, palpitation, perspiration, sensation of "butterflies in the stomach," dryness of the mouth, trembling, et cetera. These are in response to the body's normal alerting mechanism which prepares the individual for "fiight or flight." Everyone at one time or another experiences these sensations when he feels either fear or anxiety.

b. The onset of anxiety may be either acute or mild and varies in duration and expression with the individual. When the anxiety is more acute or is prolonged, the person expresses this by an intensification of the normal responses (*a* above). The feeling of apprehension may become one of acute dread or panic. The individual may suffer from insomnia, have difficulty in concentrating, and become irritable and tense. He may be unable to eat, have feelings of suffocation, have frequency of urination, or suffer from diarrhea.

105. Effects of Anxiety

Mild degrees of anxiety may have a facilitating effect on the individual; that is, the anxiety serves as a signal or warning that something is not right within and brings about constructive action to achieve a state of harmony or balance. For example, if a student of electronics is uneasy about his mathematical ability and because of this uneasiness or anxiety studies more diligently or takes an extra course, the anxiety is facilitating or has an adaptive value. On the other hand, anxiety of a more intense degree may be disruptive and even destructive in its effect. For example, if the electronics student berates himself as being too stupid to learn mathematics, he loses self-esteem, thus causing intensified anxiety which may result in failure, withdrawal from the course, or an aggressive reaction such as destroying his books and papers. There are many other responses which this student might make, but these serve to illustrate the disruptive effect of anxiety.

106. Defenses Against Anxiety

Patterns of adjustment or ego defense mechanisms (sec. V, ch. 2) are used in normal, healthy daily living. They are used in an attempt to maintain or re-establish a state of harmonious balance within the self. When the defense mechanisms are successful, the individual avoids anxiety or at least finds relief from anxiety. It is when these mechanisms fail to keep anxiety within bounds that the individual is forced to resort to exaggerated or pathological use of defenses. These exaggerations and pathological defenses interfere with the individual's ability to maintain a

socially acceptable adjustment. They then become symptoms of neurotic or psychotic illness. It is said that the intensity of anxiety, the means by which it is expressed, and the kind of defenses used against it provide a means of distinguishing between healthy and mentally sick people.

Section III. PATIENT WHO CONTROLS ANXIETY WITH PHYSICAL SYMPTOMS

107. General

a. A patient may attempt to control his anxiety by unconsciously converting his emotional conflicts into physical symptoms. The physical symptoms help him to rationalize his actions and to get attention or approval that he desperatively needs, thus preventing or relieving anxiety. The symptoms are the same as those of physical illnesses, but there is no organic cause for them. Since this patient is highly suggestible, he may develop symptoms about which he reads or hears discussed. Although he suffers "real" pain and discomfort and complains of his sypmtoms, he does not seem to be particularly concerned about them.

b. The physical symptoms most commonly used to control anxiety are numbness, tingling sensations, headache, vomiting, fainting spells, deafness, blindness, convulsions, loss of voice, loss of memory, and paralyses of all kinds. In addition to physical symptoms the patient may also have one or all of the symptoms characteristic of anxiety (par. 104). If his anxiety, accompanied by changes in body functions, exists for a prolonged period, he may develop a psychosomatic disorder—stomach ulcer, asthma, migraine headaches, high blood pressure, or other illnesses resulting from tissue damage.

108. Nursing Care Plan

a. The care plan for the patient who controls his anxiety with physical symptoms is designed to deemphasize his physical care needs and to help him learn to focus his interests away from his body and its functioning. He is provided an environment in which he can receive the attention he needs in ways not related to his physical symptoms or illness. Sufficient pressure is used to get the patient to participate in activities, thus providing him the opportunity to gain attention in a constructive manner and preventing him from spending too much time alone. Routines and activities are organized to permit a balance of work and play.

b. Care is planned to avoid taking away the patient's physical symptoms before he is able to control his anxiety. To do so would

leave him defenseless and cause his anxiety to mount. Under such circumstances he could become increasingly agitated and hyperactive. Precautions are taken to prevent, whenever possible, situations which tend to provoke the patient's anxiety. At the same time, however, care is exercised to prevent the patient from developing a passive dependence upon the personnel for the control of his anxiety.

109. Responsibilities of the Specialist

a. It is the responsibility of the specialist to provide the patient with the planned activities and experiences in a manner that is acceptable to him and beneficial to his physical, social, and emotional well-being. This is possible only through a relationship of mutual interest and trust. In order for the specialist to be able to establish such a relationship with the patient, he must accept the facts (1) that the patient's physical symptoms are motivated unconsciously, not purposely, in an attempt to control his anxiety, (2) that the patient cannot control these symptoms, and (3) that the patient is not aware that his symptoms are a means of getting attention.

b. In this relationship with the patient, the specialist helps him to satisfy his need for attention by recognizing and rewarding him for positive accomplishments, particularly for abilities to develop recreational skills and to participate in activities with others. He exercises care to avoid relating any reassurance and encouragement to his physical symptoms. When assisting him with his physical care needs, he deemphasizes these symptoms. For example, if the patient has a conversion paralysis of the arm, he does not massage the arm or apply any treatment, as this would make the symptom more important because of the attention gained from it. Instead, he assists the patient in doing the things that he is unable to do for himself because of his paralysis.

c. As the time of discharge from the hospital nears, the patient may, for a brief period, complain of the reappearance of physical symptoms. The specialist listens to the patient's complaints and accepts them matter-of-factly.

Section IV. PATIENT WHO CONTROLS ANXIETY WITH RITUALISTIC BEHAVIOR

110. General

The patient who controls anxiety with ritualistic behavior is disturbed by an irresistible impulse to carry out useless and meaningless acts (compulsions). He may also be disturbed by

constantly recurring ideas (obsessions) and morbid fears (phobias). Even though he realizes that the thoughts, fears, and acts are illogical, absurd, and purposeless, he cannot control them. His anxiety is so great that he feels compelled to perform certain rituals to relieve this anxiety or to ward off anxiety provoking situations or thoughts. For example, he may wash his hands many times a day in order to rid himself of the recurring thought that he is immoral or unclean. The patient also uses ritualistic acts to avoid making decisions which provoke anxiety. Otherwise, he becomes anxious and troubled with doubt as to whether or not he has made the right decision. The patient spends so much time carrying out ritualistic or repetitive acts that they interfere with his daily functioning. Yet, if he tries to stop these acts, upon which he has become dependent, tension and anxiety mount until the urge to repeat them becomes irresistible. If he is prevented from carrying out his rituals, tension and anxiety become intolerable.

111. Nursing Care Plan

Since the patient who controls his anxiety with ritualistic behavior has a long-standing need for absolute security, plans are designed to provide him an environment in which he does not feel threatened nor handicapped by his symptoms. This environment is one which neither isolates him nor makes him conspicuous while carrying out his rituals. The approach of the team members is aimed toward making him comfortable with and about his rituals, thus reducing the necessity for them. They carefully avoid making any statement which the patient could interpret as criticism or disapproval, as this would increase his anxiety and his need to indulge in ritualistic acts. His routines and activities are planned to allow him adequate time to carry out his rituals without pressure. Every effort is made to keep him informed of what to expect. New experiences, which are usually frightening to the patient, are first explained and then introduced carefully. Since the patient uses rituals to avoid making decisions, he is relieved, during the acute state of his illness, of making as many decisions as possible.

112. Responsibilities of the Specialist

a. In order to provide the patient therapeutic care, the specialist must have patience and understanding. Although the patient's time-consuming behavior can be annoying, he must remain alert to the fact that allowing him to complete his rituals without any feelings of pressure or criticism is an important aspect of his treatment. It is, therefore, the responsibility of the specialist

to guide the patient so that he can carry out his rituals without causing confusion or delay. For example, if the patient must go through a prolonged ritual of washing his hands before mealtime, the specialist gives him sufficient advance notice so that he can complete this act without keeping other patients waiting to go to the dining room. The specialist never interrupts nor prevents ritualistic behavior unless the phychiatrist gives a specific order to do so.

b. Since the patient usually feels less anxious immediately following the completion of rituals, the specialist takes advantage of these periods to encourage the patient to socialize and to enter into group activities. It may be necessary for the specialist to adjust routines in order to permit the patient to join group activities in which his behavior is not conspicuous or the subject of ridicule from other patients.

c. Another important responsibility of the specialist is that of carefully observing and reporting (1) situations which provoke the patient's anxiety, (2) types of ritualistic behavior in which the patient engages and the frequency of this behavior, and (3) the amount of anxiety which appears to be associated with the rituals. This information is valuable to the psychiatric team in planning or adjusting treatment and care to meet the needs of the patient.

Section V. PATIENT WHO CONTROLS ANXIETY BY PROJECTION

113. General

Projection is a defense mechanism used to avoid intolerable anxiety aroused by mistakes or unacceptable thoughts and desires by casting them upon another person (par. 34). For example, a person who hates his brother but cannot tolerate the anxiety aroused by this thought may project it upon his brother toward himself, thus believing his brother hates him. Through overuse of this projection mechanism, the person becomes suspicious of many persons because he thinks their behavior is directed against him. This mechanism becomes the core of a mental illness when this kind of thinking becomes so exaggerated that it completely controls the person's pattern of both thinking and behaving. The projections become a system of delusional thinking. Gradually, the person may involve most of the people and things within his environment into a complex plot against him. When this occurs, delusions of persecution have developed. The person can misinterpret any experience in such

a way that it will support his suspicions. The more he weaves into this delusional plot the less logic there is to what he incorporates. He may believe that his behavior is influenced or controlled by outside forces such as radar, electrical currents, or another person's mind. He may have ideas of reference through which he relates situations, such as those he sees on television or reads in the newspaper, directly to himself. Hallucinations may occur in the more serious illnesses in the form of voices threatening him or making derogatory statements against him. The person may develop delusions of grandeur instead of persecution. In this case he is convinced that he is far superior to all other persons. He may believe himself to be a great ruler of an empire or even Christ.

114. Nursing Care Plan

a. The nursing care of the patient who controls his anxiety by projection is directed toward helping him interpret his surroundings within the framework of reality without making him feel threatened. No attempt is made to reason the patient out of his delusions. The patient's right to his belief is accepted and acknowledged to him, but at the same time he is skillfully given a more realistic point of view.

b. Plans are made to keep the patient continually occupied so that he will have little time to dwell upon and further enlarge and complicate his delusional system. Activities are designed to offer him some intellectual challenge without the possibility of failure. His aptitude and previous hobbies aid in planning such activities. He is given opportunities to experience interpersonal relationships with other patients but to only a limited extent at first. Because of his suspicious, sarcastic, or superior attitude toward other patients, care is exercised to prevent conflict and retaliation. The patient's overall program is made sufficiently routine to give him security yet sufficiently varied to avoid monotony. Any somatic therapy which the psychiatrist orders for the patient is incorporated into his care program.

c. This patient is quite capable of taking care of his physical needs; he is usually meticulous about his hygienic care. He may, however, require special attention regarding his nutrition. Frequently, he feels that his food has been poisoned. When such a feeling occurs, plans are made for dealing with his individual problem (par. 80*g*).

115. Responsibilities of the Specialist

a. The specialist is responsible for building a relationship which contributes to the patient's security and which provides

him a link with reality. Since the patient sees all other persons as a threat to his security, the specialist keeps the relationship as formal as possible. He recognizes and accepts the fact that the patient's behavior invariably causes others, including himself, to be on the defensive and want to retaliate. He, therefore, not only maintains control of his own feelings but also handles situations to prevent conflicts between this patient and other patients and retaliation by them. He deals with any sarcasm and suspiciousness in a matter-of-fact manner and does not argue with the patient. He learns the topics about which the patient is most sensitive and avoids comments or answers which would likely arouse his negative feelings or threaten his self-esteem. He enhances the patient's sense of importance in a constructive way by praising his real abilities and daily accomplishments.

b. In dealing with the patient's delusional ideas, he carefully avoids agreeing or disagreeing with the patient. He listens attentively and responds in ways which acknowledge the patient's right to his belief but which remind him of what is realistic (par. 59*b*(3)). He reports who and what is involved in the patient's delusions to aid other team members in guiding the patient's thoughts into constructive channels.

Section VI. PATIENT WHO IS WITHDRAWN

116. General

The withdrawn patient, like all other people, characteristically has a strong need for emotional ties with other persons as well as a strong need for self-esteem and self-respect. He needs to be loved, socially accepted, and respected as someone of worth; but he, being basically insecure lacks the self-confidence and the emotional warmth necessary for forming successful interpersonal relationships. Because he feels inferior to other persons, he develops indifference toward them. He, in essence, says, "Since you reject me, I will turn my back on you and give all of my attention to myself." He compensates for his emotional inadequacies and loneliness by focusing his attention solely on thoughts concerning himself. He becomes disinterested in such things as personal appearance, eating, and exercise as though dissociating himself from his body. Usually, he is extremely sensitive and sees the world as hostile. His pattern of behavior may become exaggerated to the degree that he loses contact with reality. He may withdraw so completely into himself and into his own little immediate world that he appears neither to need nor to desire communication with others. He exhibits complete disinterest in his environment.

117. Nursing Care Plan

a. The nursing care plan for the withdrawn patient is based on the realization that he is experiencing marked feelings of insecurity in interpersonal relationships and that he is unable to participate with others because he fears rejection. Nursing care is directed first toward reaching the patient emotionally and gaining his confidence and trust. This helps the patient to reestablish his contact with reality and provides the basis upon which he can build a more successful and satisfying pattern of behavior and response. Nursing care is then aimed toward helping the patient develop a different perception of himself in relation to other people. Emphasis is given to helping him replace negative feelings about himself with positive ones.

b. Since the patient's greatest basic need is security, nursing care is planned to avoid experiences which he cannot meet successfully. During the acute phase of his illness, activity is planned so as to require only a minimum of mental effort or concentration on his part. Routines and activities are made only varied enough to avoid monotony and are carried out consistently every day. This helps the patient feel more secure in that he knows what to expect and what is expected of him. Inasmuch as the patient has become retarded in both moving and thinking, sufficient time is allowed to avoid giving him any feeling of being forced or pushed beyond his capability, thus preventing him from retreating further. Encouragement to try more varied and difficult activity is increased very gradually. Group activities and socialization are slowly introduced into his care program only when he is ready for them. Until the time that he progresses toward independence, most decisions are made for him.

c. Since the withdrawn patient has neither the energy nor the interest to do anything for himself, care plans include provisions for giving him more physical care and attention than are ordinarily required for most patients. For example, he needs much encouragement to take the minimum amount of exercise and to eat sufficient nutritional food. Because of his tendency toward suicidal thoughts, he also needs to be observed closely for signs of suicidal intention.

118. Responsibilities of the Specialist

a. To reach the withdrawn patient emotionally and gain his confidence and trust, the specialist must be able to approach the patient over and over again in a consistently friendly manner without demanding any response from him and without becoming discouraged or disinterested from lack of response. The specialist talks in simple terms and only for brief periods. He is

observant of any nonverbal response such as gestures, movements, or facial expressions (par. 59*a*). The specialist may find that the best way to show his sincere interest and to offer the most security is simply to remain quietly with the patient for awhile.

b. Despite the fact that the patient may not be in contact with reality and may resort to careless personal exposure, indiscriminate defecation, and complete disregard for personal cleanliness, the specialist avoids any open expression of disgust. He accepts such behavior in a matter-of-factly manner and provides him the care he needs. The specialist encourages the patient to exercise to the extent that he is able. Realizing that the patient lacks the initiative to complain even when he is experiencing pain, he observes him carefully for any symptoms of physical illness. He closely observes his nutritional intake and encourages him to eat. He remains constantly alert for signs which indicate that the patient may be planning suicide; he knows where the patient is and what he is doing at all times (par. 88). He also protects the patient physically and psychologically from other patients who may be overly aggressive.

c. When the patient becomes more alert to what is going on around him, the specialist gradually encourages him to try more varied and difficult activity. He accepts poor results without any indication of critism but praises the patient freely for progress, regardless of how minor. He helps the patient to see his progress, thus alleviating some of his negative feelings.

Section VII. PATIENT WHO IS OVERACTIVE

119. General

Overactivity is intense activity, usually without direction. It can be manifested both verbally and physically. One patient may talk, sing, or write all day; or he may walk, run, and dance. Another patient would, if allowed, scrub floors, clean toilets, or make beds indefinitely. There is also the patient who becomes angry and argumentative and who may attempt to destroy his own and other property or to harm himself or others (sec. IX, ch. 5). The overactivity is an expression of the patient's anxiety which may mount for various reasons. For example, the patient may see another patient upset, may be frightened of a treatment that he is to receive, or may be fearful of what he might do.

120. Nursing Care Plan

a. Nursing care for the overactive patient entails, first of all,

protecting him from overstimulation. His environment needs to be unchallenging and nonstimulating. Every effort is made, therefore, to keep the ward environment as quiet as possible. Arrangements are made for a quiet, neutral area where the patient may go to get temporary relief from the environment elements which are stimulating to him.

b. Since protective needs of the overactive patient are quite high, care is exercised to provide him the essential protection without placing unnecessary limitations or restrictions upon him. All members of the team follow through consistently with restrictions planned for the patient, thus making him feel more secure in that he knows exactly what to expect. At the same time, the patient is allowed to verbalize his resentment of such restrictions. Protective measures such as locking doors and counting patients are carried out as tactfully as possible.

c. The patient's daily routines are carefully planned to avoid irritating him. Plans are made for allowing the patient to work off his excess energy in constructive ways, thus avoiding destructive behavior. Diversified activities, which include housekeeping duties as well as recreational and vocational activities, may help to keep the patient's energy directed into constructive channels.

121. Responsibilities of the Specialist

a. In providing the overactive patient therapeutic nursing care, the specialist accepts the overactivity as the patient's way of responding to intolerable anxiety. Regardless of the nature of the patient's overactivity, the specialist consistently approaches him with calmness and understanding.

b. In communicating with the patient, the specialist takes into consideration the patient's limited attention span, distractibility, sensitivity, need to express hostility, and need to be funny. He gives him short, simple explanations. If a decision has to be made, he makes it quickly and firmly because of indecisiveness tends to increase the patient's anxiety. He guards against the tendency to encourage the patient when he is witty or funny, thus avoiding overstimulation.

c. The specialist is aware of the fact that mounting tension in the overactive patient can lead to exhaustion, injury to self or others, and suicide. He, therefore, closely observes the patient for indications of mounting tension, such as voice change, tense muscles, and increased irritability. When such signs appear, he guides the patient into an environment where he can get relief from the situation or the elements which are making him more

tense and anxious. Through close observation of the patient the specialist becomes familiar with the ways in which the patient characteristically responds to situations and conditions. He reports such observations which aid in planning nursing care that best meets the individual needs of the patient.

d. Since the overactive patient is careless in regard to his personal appearance, personal cleanliness, and physical health, the specialist gives the patient as much assistance with his physical care as he needs. He insures that he eats and drinks enough fluids so that he does not develop faulty elimination or become dehydrated. He observes him closely for any symptoms of physical illness.

Section VIII. PATIENT WHOSE BEHAVIOR IS ANTISOCIAL

122. General

a. Antisocial behavior is a disorder in the personality. It lies in the zone between mental health and mental illness. There are no specific clinical symptoms. It is manifested by the inability to make adequate social adjustments. Emotional conflicts are expressed through behavior patterns which indicate a faulty superego functioning. This disorder differs from the neurotic and psychotic illnesses primarily in the degree of anxiety which the person feels. The person with an antisocial personality disorder appears to feel only minimal anxiety.

b. Antisocial behavior patterns are formed at an early age. The history of an individual with such behavior patterns reveals predominantly a lack of conscience, which is probably the result of conflicting guidance from parental figures during childhood, making it impossible for him to identify with either parental figure. Also, childhood frustrations brought about by unsuccessful attempts to achieve satisfactory fulfillment of basic needs for love, security, and recognition may result in resentment, rebellion, and antisocial behavior. The emotional maladjustment and undesirable personality traits formed early are reflected throughout life by impulsive and instant response to feelings of the moment.

c. The person with antisocial behavior may make a good first impression. He may appear to be reliable, dependable, sincere, honest, charming, and gracious; but he soon reveals that he has no sense of responsibility for his acts and no regard for the truth. He lies, steals, and cheats without concern or remorse. He likes attention and resorts to any means to get it; he shows no consideration for the needs or rights of others. Likely, he has brought misfortune to himself many times because he is unable to profit from

mistakes or to forego immediate pleasures for future gains. He usually attributes all his difficulties to circumstances. He seldom responds to kindness and consideration. He cannot stand frustration in any form and may react to it with violent types of tantrums. He craves excitement and glamour and seeks frequent changes of environment. For this reason, the person is attracted to military life. Because of the way he deals with stress and tension, which are usually aggravated by pressure of authority and conformity, he causes the same type problems in the military service that he did in civilian life. He resents authority and cannot conform to regulations or routines. He is unreliable in carrying out his duties. His behavior tends to lower the morale of the group. Although this person is not ordinarily a calculating criminal, he becomes involved in criminal conduct because of his impulsiveness.

d. When an individual with antisocial behavior is admitted to a military hospital, it is usually for observation for possible psychosis or severe neurosis; he may be admitted on an emergency basis as the result of uncontrolled behavior. Once it is determined that the patient's behavior is antisocial, he is considered unfit for military service and is given an administrative discharge. He is not entitled to a medical discharge, since his behavior disorder is considered to be symptomatic of a deviation in the basic personality structure rather than a mental illness. The individual is usually retained in the hospital until his discharge is effective, primarily to keep him out of further difficulty.

123. Nursing Care Plan

The patient's long developmental background, plus the fact that he is usually unable to gain insight and an awareness of his need for help, makes any modification of his behavior patterns extremely difficult. Modification to any extent entails long-term psychotherapy which is not provided in military medical facilities. The care plan, therefore, is designed to help the patient meet his needs in a more socially acceptable way while he is in the hospital. This is also most difficult because his basic problem is his behavior. He rebels against any kind of authority, is uncooperative toward ward rules and regulations, disregards orders and routines when they do not meet with his approval, makes excessive demands for attention, and frequently attempts to create dissension among other patients and personnel. If he is retained on the closed ward, he resents being confined. Preparing an effective plan for escape becomes a challenge to him, and he delights in secreting hazardous items. Since this patient is basically fearful and insecure, he usually profits most from relationships which

offer him emotional security. Plans are, therefore, made to maintain a consistent approach to him; to provide objective acceptance, friendly firmness, and calm reassurance; and to place definite, consistent limitations on his behavior, thus holding him firmly to his obligations and responsibilities.

124. Responsibilities of the Specialist

The specialist follows through with the care plans. He maintains a consistent approach of friendly firmness regardless of the patient's persuasiveness or the plausible reasons that he may give in an attempt to do what he wishes. He creates a therapeutic environment for the patient by allowing him to express his hostility and aggression constructively, by accepting his excessive demands as ways of testing the sincerity of those trying to help him, and by accepting his explosiveness and contrasting charming behavior from an objective point of view. Objectivity concerning the patient's behavior helps the specialist control his own emotions so that he can respond to the patient in a more therapeutic manner. The specialist gives the patient the attention he craves, thereby avoiding the need for him to seek it through undesirable behavior. He provides for the patient's material needs and arranges varied and challenging activities which offer opportunities to help the patient learn concepts of good sportsmanship, to become more successful in social contacts, and to develop a sense of responsibility as well as tolerance in frustrating situations. He also protects the patient from his own acting out.

Section IX. PATIENT WHO DEPENDS UPON AN EMOTIONAL CRUTCH

125. General

The patient who depends upon an emotional crutch such as alcohol, opiates, barbiturates, or other narcotic substances to escape anxiety, guilt, or difficult life situations has a psychiatric disorder. The addiction to alcohol or drugs is only a symptom of an underlying psychotic, neurotic, psychosomatic, or character and behavior disorder. The person uses alcohol or a drug to satisfy deep-seated psychological needs and to relieve anxiety brought about by tension, stress, conflicts, and frustrations. Whereas some individuals who are emotionally dependent and immature develop symptoms such as phobias and compulsions, others resort to excessive drinking or use of drugs. Indulgence in such a method of escape may become a firmly established reaction pattern which is comparable to other defensive behavioral patterns used to relieve anxiety.

126. Conditions Resulting From Alcohol and Drug Addiction

a. Excessive or prolonged use of alcohol leads to an extremely poor physical condition, caused by inadequate nutritional intake. The lack of carbohydrate, protein, and especially vitamin B complex in the diet leads to other conditions known as delirium tremens and Korsakoff's psychosis. An alcoholic may develop either one of these conditions without developing the other; however, repeated occurrences of delirium tremens are frequently followed by Korsakoff's psychosis. When a person develops one of these conditions, he is admitted to the hospital.

(1) *Delirium tremens.* This is an acute condition frequently referred to as DT's. The symptoms include disorientation of time and place; intense visual hallucinations, which are usually of small animals and insects; acute fear; extreme suggestibility; and marked tremors of the fingers, tongue, and lips. The somatic symptoms are primarily excessive perspiration; a rapid, weak, and thready pulse; elevated temperature; and a coated tongue. The delirium, which usually lasts from 3 to 6 days, is ordinarily followed by deep sleep after which the patient recovers rapidly.

(2) *Korsakoff's psychosis.* This is a chronic organic condition, which is also present in other organic disorders. The outstanding symptom is a memory defect for events during a recent period of time. Characteristically, the patient fills in the period with imaginary events which he believes to be true. Other symptoms include tingling sensations, pain, and tenderness of the feet and legs; he may have foot drop which prevents him from raising his foot. Korsakoff's psychosis is due primarily to a vitamin B complex deficiency which has resulted in degeneration of some of the nerve cells of the brain and the body. (For further information regarding the nervous system, see TM 8–230.) Personality deterioration progresses gradually with decreasing intellectual capacity and a lowering of moral and ethical standards.

b. Inasmuch as the drug addict is not usually treated in the military, the many conditions which result from excessive or prolonged use of drugs are not discussed in this section.

127. Therapy

a. The therapy provided the patient who depends upon alcohol or a drug is based on the fact that the addiction is the result rather than the cause of his problem. Although acute reactions

require medical care of an emergency nature, effective therapy entails re-educating the patient psychologically so that he can adjust to the social environment without feeling the need to lean on a deceiving crutch. Such a re-education process, through psychiatry, requires prolonged individual and group psychotherapy in a hospital situation where the patient does not have access to the substance to which he is addicted but has the psychological support that he needs. In the hospital the patient is also away from the environmental stresses which overwhelm him and in an atmosphere where there is warmth, acceptance, and understanding. Such long-term psychotherapy is not available in military hospital facilities. If the patient is retained in the military service, psychotherapy is available to him through the Mental Hygiene Consultation Service in an out-patient basis.

b. Alcoholics Anonymous—a social-religious organization of alcoholics who have learned to cope with life instead of resorting to alcohol—has proved to be most effective in rehabilitating alcoholics. Through inspiration and mass-suggestion this organization arouses in its members a deep desire to help others and a sense of responsibility for doing so. The personal and group support and acceptance which these individuals provide the alcoholic have proved to be even more effective than individual professional psychotherapy. Of primary importance to the effectiveness of both the therapy provided by *Alcoholics Anonymous* and professional psychotherapy is complete abstinence and efficient psychological support and acceptance. There is no such lay organization available to the drug addict.

128. Prognosis

Permanent abstinence is possible if the patient learns to face his problems instead of retreating from them and gains some measure of insight into his immaturity and emotional instability. If long-term treatment is attempted on an out-patient basis, the patient must receive sufficient emotional support to maintain abstinence; otherwise he may succumb to the first stressful situation that arises. *Alcoholics Anonymous* is often able to provide this support. The prognosis is poor if the individual refuses to admit his alcoholism or lacks the will power to cooperate in therapy.

129. Nursing Care Plan

a. The first step in the care plan for the patient who depends upon an emotional crutch is the discontinuance of the substance to which he is addicted, except when addicted to opiates. Opiates are withdrawn gradually by giving the patient reduced dosages

before discontinuance. During this early period of hospitalization, care is based primarily on the physical condition of the indiivdual patient and is specifically ordered by the psychiatrist. The patient is ordinarily given high caloric, high vitamin foods and fluids as soon as tolerated and sedatives and tranquilizers as indicated. He is provided a nonstimulating environment and constant supervision to prevent him from injuring himself while he is in the highly excited state induced by hallucinations or delusions.

b. Following the acute phase of the patient's condition, physical care becomes less necessary, and psychological support becomes of primary importance. The approach to the patient must be accepting but firm; it must be one of understanding but not indulgence. The patient must be made to feel that the personnel are sincerely interested in him and that they respect him as an individual. Patient care plans are designed to cope with the patient's tendency to overestimate his ability to abstain once he feels physically well and to lessen his anxiety, resentment, and hostility when he is not allowed to leave the hospital environment. The psychiatrist permits the patient to take trips away from the hospital only after careful appraisal of his condition. Coping therapeutically with the patient's hostile feelings and his unwillingness to face his problem requires tolerance of the patient's behavior without retaliation. It also requires plans for getting the patient to participate in activities with other patients and for encouraging him to use his special abilities and talents.

130. Responsibilities of the Specialist

a. In administering nursing care during the acute phase of the patient's condition, the specialist follows, with guidance from the nurse, the psychiatrist's orders; maintains a quiet and restful environment; prevents the patient from injuring himself; and takes care of his hygienic needs. In accomplishing these responsibilities, he maintains a calm, assured, and patient approach.

b. As the patient improves and psychological support becomes of primary importance, the specialist's approach to the patient is one of acceptance and understanding. He establishes with the patient a relationship that contributes to the patient's feelings of self-respect, self-confidence, and comfort and maintains an emotional environment that convinces him that he can be rehabilitated. He follows through with the care plans in a way to establish for the patient a balance routine of physical exercise, rest, work, and recreation and to make him feel that socialization is worthwhile. To make socialization acceptable to the patient, the specialist creates an atmosphere in which the patient's hostility

and negativism regarding enforced abstinence are accepted without judgment or criticism and in which the patient can recognize the fact that people are interested in him. Throughout this program of care the specialist decreases the patient's feeling of dependency and encourages independence.

Section X. PATIENT WITH AN ORGANIC BRAIN DISORDER

131. General

a. The patient with an organic brain disorder has both physical and mental symptoms. The severity of the physical symptoms depends upon the nature and extent of damage to the central nervous system. The severity of the mental symptoms correlates with the degree of the previous emotional instability and immaturity rather than the amount of neural damage. Since the nervous system, however, represents the essential basis for the integration of behavior, there are limits to the amount of neural damage which the patient can tolerate or for which he can compensate without manifesting symptoms of mental disorder. The mental symptoms occur because of damage to brain tissue or loss of brain tissue in that part of the brain which helps the person maintain self-control. Consequently, a latent or hidden personality problem, such as a neurotic or psychotic reaction, may appear. The basic psychological symptoms directly associated with all organic brain disorders are impairment of orientation and decrease in intellectual functioning such as impairment or loss of memory, especially of recent events, poor judgment, lack of comprehension, and confusion.

b. Organic disorders of the brain are classified as acute and chronic. If the brain function is completely restored, the disorder does not become chronic. If the impairment is so severe as to become permanent, the disorder is then classified as chronic.

(1) *Acute.*

(*a*) The acute phase of disorders is characterized by a sudden onset. Generally, they are due to a diffuse impairment of brain tissue functions, resulting from minor head injuries or toxic conditions such as those which accompany brain infections, high fever, drug or alcohol intoxication, and nutritional deficiencies. The basic neurological symptoms are pupillary changes, tremors, muscular weakness or paralysis, and sensory disturbances. The basic mental symptoms range from mild mood changes (irritability and suspiciousness) to acute delirium which may be complicated by de-

lusions, hallucinations, and other personality disturbances. The patient is often more aware of what is transpiring than is apparent and is afraid and confused. The patient's progress is sometimes seriously hindered by the occurrence of a convulsion, which is indicative of a more serious condition and requires immediate emergency treatment.

(*b*) Provided the causative agent is promptly diagnosed and appropriately treated, the acute disorders are usually self-limited and relatively short in duration. Once the symptoms manifest themselves to the maximum degree, recovery begins. There is an almost daily decline in both the number and severity of symptoms. On the other hand, lack of prompt and appropriate treatment can lead to a chronic condition; the acute condition leaves some residual damage of a chronic nature.

(2) *Chronic.* The chronic or permanent damage usually occurs gradually and is progressive. Ultimately, the disease process results in destruction of nerve cells which cannot be replaced. This damage results from such diseases as cerebral palsy, multiple sclerosis, cerebral arteriosclerosis, encephalitis, prolonged alcoholism, and some severe brain injuries. In some of these diseases there is no acute phase. The outstanding symptoms are marked emotional instability and oversensitivity, failing physical capacities such as muscular coordination and strength, general and gradual deterioration in conduct and standards with carelessness in personal appearance, loss of interest in occupation and family, and lowered moral controls.

132. Therapy

a. Acute. Therapy for the patient with an acute disorder is directed first toward the elimination of the toxic agent and then toward the rehabilitation of the patient's personality, if indicated. For example, therapy for the drug or alcohol addict is aimed toward helping him gain insight into his difficulties which lead to the need for the emotional crutch. As the symptoms of the acute illness disappear, the need for physical care decreases; and the need for psychological support increases.

b. Chronic. The central objective of therapy for the patient with a chronic disorder is to build his confidence and self-esteem and to help him learn to live effectively and constructively with

his handicap. Slowly, the patient is encouraged into activity until he is participating at the highest level of his physical capabilities. The physical care needs of the patient increase as the disorder progresses.

133. Prognosis

a. Acute. Once the patient is free of the toxin, recovery is usually rapid. When treatment is started promptly, there is seldom any permanent damage to the central nervous system.

b. Chronic. The disease gradually causes degeneration of the central nervous system tissue and deterioration of the personality.

134. Nursing Care Plan

a. Acute. The nursing care plan for the patient with an acute disorder includes complete bed rest and constant observation in order to prevent the patient from injuring himself while he is delirious and to note and report any symptoms indicating the onset of a convulsion. The room is kept dim and quiet but never completely dark. As soon as the patient is able to tolerate nutrition orally, he is given a high caloric, high vitamin diet of food and fluids. He is given an abundance of fluids daily; a record is kept of the intake and output. Ordinarily, vitamin B complex is administered intravenously or intramuscularly. Frequently, it is necessary to lower the patient's elevated temperature with alcohol sponges.

b. Chronic. The nursing care plan for the patient with a chronic disorder is based on the severity of the symptoms as they appear. Exercise is carefully geared to the patient's ability, thus avoiding complete incapacitation. Routines are carried out consistently so that the patient can rely upon past habits and maintain orientation. New experiences are kept to the minimum. As the patient's illness progresses, nursing care is adjusted to meet his increased physical care needs. Careful attention is given to diet and elimination, since the patient usually loses concern about his physical condition. The patient's environment is made pleasant and cheerful.

135. Responsibilities of the Specialist

a. Acute. The specialist is in continuous attendance of the acutely ill patient, who is completely dependent upon others for his physical care. His approach to the patient is one of understanding and acceptance. Since the patient is in a constant state of confusion, he gives him reassurance in a firm and positive manner as frequently as necessary to allay his fear and appre-

hension. He reports immediately any unusual symptom such as the onset of a convulsion.

b. Chronic. For the chronically ill patient, who has only a few responses left for adaptive purposes, the specialist is responsible for assuring consistency in the routines of his daily care so that he has no need to adjust to changes. He guides the patient into activity, gradually increasing it in line with his abilities and encouraging improvement until he reaches his maximum level. Through a calm acceptance of the patient's defects, he helps the patient to accept them. He observes the patient closely for signs and symptoms of increasing debility, which may indicate the need for re-evaluation of the nursing care plan.

Section XI. PATIENT WITH EPILEPSY

136. General

Epilepsy is a condition which is characterized by periodic impairment of consciousness and usually by muscular movements that range from a slight twitching of the eyelids to a violent contraction of all voluntary muscles of the body. The cause of epilepsy is not always known. When there is no known cause, it is called idiopathic epilepsy. When the condition is the result of infectious diseases, arteriosclerosis, head injuries, or other organic conditions, it is called symptomatic epilepsy.

137. Types of Epilepsy

The types of epileptic seizures are grand mal, petit mal, Jacksonian, psychomotor, status epilepticus, and hysterical.

a. Grand Mal.

(1) *Explanations.* The grand mal is the most comon type of seizure. A few seconds before this seizure begins the patient may have a warning, known as the aura. This may be a strange feeling in the stomach, a peculiar sensation in some part of the body, an unusual taste, flashes of light, or a buzzing noise. There may be a groan or cry. When the seizure begins, the patient falls unconscious. The muscles of his entire body contract and become completely rigid. The patient clamps his jaws together and may bite his tongue severely if it falls between his teeth. His face becomes pale and then cyanotic. His eyes, the pupils of which are dilated, become fixed. At this time he may become incontinent of urine. This first phase, which lasts from ten to twenty seconds, is called the tonic phase of the seizure. It is followed by

the clonic phase, which may last two to three minutes. During the clonic phase there are alternating contractions and relaxations of the muscles. As the patient starts breathing, he froths at the mouth. If he has bitten his tongue, the saliva may be blood-tinged. Gradually, the jerking becomes less severe, and cyanosis disappears. After the seizure the patient usually goes into a deep sleep, which sometimes lasts several hours. When he awakens, he may be confused and disoriented and may complain of headache and muscle soreness.

(2) *Care of the patient during seizure.* The patient is left lying where he falls until the seizure is over. Clothing around his neck and waist is loosened to aid him in breathing. An object such as a mouth gag is placed between his teeth to prevent him from biting his tongue. If the patient has his jaws clamped together, they are not pried open; the object is slipped between his teeth when he opens his mouth the first time. The patient's head is held to one side so that saliva can run out of his mouth. His movements are not restrained forcefully, but he is held lightly to prevent him from injuring himself. After the seizure is over, his body is examined for injury. He is then placed in bed and permitted to sleep.

(3) *Report of observations.* A report containing answers to the following questions is made following a seizure:

(*a*) Did the patient appear confused or show any unusual behavior before the seizure?

(*b*) Did he groan or cry out?

(*c*) In what part of his body did the seizure begin?

(*d*) Were there both tonic and clonic spasms, and how long did each last?

(*e*) How long was the patient unconscious?

(*f*) Did his face and lips become cyanotic?

(*g*) Did he bite his tongue or lips?

(*h*) Did he froth at the mouth?

(*i*) Did the pupils of his eyes react to light, contract, or dilate?

(*j*) Did he have any bruises or injury?

(*k*) How long did he sleep after the seizure?

(*l*) What were his complaints upon awakening?

(*m*) What does patient recall prior to seizure, especially what physical or emotional stress?

b. Petit Mal. The petit mal seizure, sometimes described as a "blank or staring spell," is a momentary loss of consciousness, often accompanied by twitching of the face and eyes. The period of unconsciousness is so brief that the patient does not fall. He is not confused after the seizure; he resumes his normal behavior. The petit mal seizure occurs mostly in children.

c. Jacksonian. The Jacksonian type of seizure is caused by a localized irritation in a motor area of the brain. The seizure may involve only certain groups of muscles on one side of the body or may spread throughout the entire body, terminating in a generalized convulsion accompanied by a loss of consciousness. When the seizure remains limited to one part of the body, consciousness is usually retained.

d. Psychomotor. The psychomotor seizure is manifested by various types of behavior. The behavior may vary from a stereotyped repetition of certain movements to violent attacks. In most cases, it seems purposeful but inappropriate for the time and place. The period of the seizure varies from a few seconds to hours or, in rare cases, several days. Although the patient may appear conscious during this period, he is totally unaware of what he is doing. The period is sometimes described as a "trance-like state."

e. Status Epilepticus. When a patient has rapidly recurring grand mal seizures without regaining consciousness between them, the condition is called status epilepticus. After a day or two of intensive medical treatment the seizures usually stop at which time the patient regains consciousness. If the treatment is not effective, the seizures continue and result in death.

f. Hysterical.

(1) The hysterical seizure is not a true type of convulsion. Although this seizure may resemble the true epileptic convulsion in that there may be severe tremors or rigidity of the body, it can be distinguished from a true convulsion in a number of ways. It ordinarily occurs in the presence of others. The patient falls slowly without injuring himself. He usually keeps his eyes closed so tightly that it is difficult for another person to raise his eyelids. He moves his head from side to side and may twist his body or thrash about as if in pain. These movements may be intensified by efforts of restraint. Although the patient may clench his teeth, he will not bite his tongue. He is not incontinent. After the seizure he is not confused.

(2) Until such time as the psychiatrist determines that the patient's seizures are hysterical reactions, he is given

the same care during a seizure as that given to a patient with a grand mal seizure (*a* (2) above). After such determination is made, care during the seizure is given as ordered by the psychiatrist. Emphasis is placed on preventing such hysterical seizures by helping the patient meet his needs in more constructive, satisfying ways.

138. Therapy

The patient who has epileptic seizures is given anticonvulsant drugs. In most cases, the drugs will fully control the seizures; in many other cases, they will reduce the number and severity of the seizures considerably. Such medication may be required for the remainder of the patient's life. After the patient's seizures become controlled or reduced, therapy is directed primarily toward helping the patient to accept his condition and to learn to live with it effectively.

139. Prognosis

Early detection and treatment of the patient's condition is very important. The prognosis is best for the patient who has no brain injury and only occasional seizures which start after childhood.

140. Nursing Care Plan

The specific nursing care plan for the patient who has seizures is based upon the severity of the patient's condition. The plan is designed to get the patient to take part in activities but, at the same time, to protect him from activities in which he could become injured if he were to have a seizure. The physician specifies the activities in which the patient cannot participate. Arrangements are made for the patient to sleep on a low bed. After the seizures are controlled, the plan is designed to help the patient to live as normal a life as possible.

141. Responsibilities of the Specialist

The primary responsibilities of the specialist are to provide the patient with the proper care during the seizures (par. 137*a*(2)) and to report accurately his observations of the patient during the seizures (par. 137*a*(3)). Such observations aid in diagnosing the patient's condition and in planning treatment and care. The specialist provides the patient calm, realistic support by guiding him into activities which serve as emotional outlets and increase his self-esteem and by helping him to accept his condition and learn that he can live with it effectively.

Section XII. PATIENT WHO IS TO BE DISCHARGED

142. General

a. A patient is discharged from a military hospital to duty, to another hospital (military, veterans, or state), or to his home. In most cases, he is returned to duty. Before a patient in the military service can be discharged to a state or veterans hospital or to his home, he must receive a discharge from the military service.

b. Therapeutic nursing care throughout the discharge routines is essential to the emotional well-being of the patient. He not only needs assistance with the routines pertaining to his personal property and physical preparation but also needs emotional reassurance, support, information, and guidance. Every effort is made to help him maintain whatever feeling of security he has gained while in the hospital environment.

143. Therapeutic Discharge Care

a. Emotional Prepartion. Although the psychiatrist and the clinical social worker assist the patient in planning for the adjustment to be made after he leaves the hospital, the specialist is the person to whom the patient directs many of his questions and most freely expresses his anxieties. If the patient is returning to duty or to his home, he is usually most concerned about whether or not people will accept him after being mentally ill and about how he can re-establish himself. Overly optimistic and offhand replies can be detrimental to the patient's future adjustment attempts. The specialist should listen carefully to the patient and make an honest attempt to help him work through these problems and decide how he can best meet the situations as they arise. The most valuable assistance that he can give the patient is to help him adopt a realistic, confident point of view. If the patient is being discharged to another hospital, he probably feels anxious about going into a new environment with people who are strangers to him. The specialist should assure the patient that the personnel there will also be interested in his welfare, that the routines will be much the same, that his personal possessions will be forwarded immediately, and that he will be given good nursing care en route. The specialist's sincere interest and kindness will make him more confident about the care he will receive in the future. All personnel should make it a point to say goodbye to the patient and to reassure him of their friendly feelings and interest in him.

b. Assistance With Discharge Routines. The patient to be discharged from the open ward is usually able to take care of the discharge routines himself; however the specialist gives him what-

ever information and assistance he needs. When the patient is to be discharged from the closed ward, the specialist is responsible for carrying out the discharge routines smoothly and efficiently.

(1) The specialist packs, in a way convenient for use, a limited number of personal items which the patient will need en route. He insures that all the other items which the patient has on the ward are turned in to the clothing room to be packed with his other possessions.

(2) He escorts the patient to the Patient Trust Fund office where the patient withdraws his money and valuables or arranges to have them mailed and to the clothing room where he checks out the clothes he needs to wear en route, turns in items not needed en route, and arranges for the shipping of his clothing and personal items to his destination. The specialist also escorts the patient to the personnel and finance sections for final clearance. If the patient is too ill to go to these various offices, the specialist checks out the clothing which the patient will need in travel and arranges for the mailing or shipping of his possessions and for other clearances.

c. Physical Preparation. Well in advance of departure time the specialist insures that the patient has had a shower, oral hygiene, nail care, shave, shampoo, and a good meal and that he is properly dressed in his uniform or civilian attire. Just prior to departure time the specialist makes sure that the patient goes to the latrine, has something to eat and drink, and has his personal items with him.

144. Preparation for Military Air Travel

When a patient is discharged to another military hospital, arrangements are made for Air Force transportation. To insure the comfort and safety of the patient, the Air Force requires that one of three classifications (*a* below) be given to the patient by the psychiatrist and that the patient be prepared for air travel in accordance with prescribed specifications and procedures.

a. Classifications of Patients and Specifications.

(1) Class 1A—an actively psychotic patient (locked ward status).

(*a*) Hospital pajamas and, in cold weather, socks.

(*b*) Sedation.

(*c*) Mechanical restraint.

(*d*) Litter.

(2) Class 1B—a potentially psychotic patient (locked ward status).

(*a*) Hospital pajamas and, in cold weather, socks.

(*b*) Sedation.

(*c*) Litter.

(3) Class 1C—a patient who is not potentially or actively psychotic.

(*a*) Class A uniform.

(*b*) Ambulatory.

b. Preparatory Procedures. In addition to the discharge care (par. 143), the following procedures are carried out in preparing a patient for travel by military aircraft:

(1) The patient is prepared psychologically by giving him a simple, honest explanation as to why certain procedures are necessary in air travel and by reassuring him about the care he will receive en route and about the safety of his personal possessions and valuables. Within the continental United States valuables do not accompany the patient classified as 1A or 1B; they are mailed to the hospital of destination.

(2) A sedative is administered by the nurse to the patient classified as 1A or 1B 20 to 30 minutes before departure time. The sedative is administered to a Class 1A patient after he is placed on the litter and before the mechanical restraint is applied (par. 146) and to a Class 1B patient before he is placed on the litter. After the sedative is administered, the patient is kept in a quiet, pleasant environment and observed closely to prevent fall or injury.

(3) A Patient's Identity Tag (DD Form 602) is attached to the patient's clothing. This tag, which is used as the patient's chart en route, contains such information as name, service number, classification, diagnosis, treatment recommended en route, and the names of the hospitals of origination and destination.

(4) A supplementary identification tag is attached to the foot of the litter of the patient classified as 1A or 1B. This tag contains the name, rank, serial number, and classification of the patient, the name of the sedative administered and the time, and the names of the hospitals of origination and destination.

(5) A Patient's Baggage Tag (DD Form 600) is securely affixed to each piece of baggage which accompanies the patient on the aircraft.

(6) The patient classified as 1A or 1B is placed on a litter as described in paragraph 145.

(7) Mechanical restraint is applied to the patient classified as 1A as described in paragraph 146.

145. Preparation of Litter and Placement of Patient

The patient classified as 1A or 1B is placed on a litter to insure his comfort and safety en route.

a. Equipment. The equipment consists of 1 litter, 3 blankets, 2 sheets, 1 pillow, and 1 pillowcase.

b. Procedure.

(1) The first blanket is placed lengthwise on the litter with one edge parallel to and even with the litter pole. It is then folded over the litter, the fold being even with the opposite litter pole. The remaining one-third of the blanket is allowed to hang over the side of the litter.

(2) The second blanket is placed over the first one and folded in the same manner except that the procedure is started with the opposite litter pole.

(3) The sheets are placed on the litter in the same way as the blankets.

(4) If the patient is not placed on the litter immediately after it is prepared, the parts of the sheets and blankets extending over the sides of the litter are fan folded.

(5) A pillow is placed on the litter for the patient's head.

(6) When the patient is placed on the litter, the sheets are folded over him, and he is covered with a third blanket folded in half lengthwise. The flaps of the first two blankets are then put over the third blanket so that the litter is dressed with four thicknesses of blanket under and over the patient.

146. Application of Mechanical Restraint and Care of Patient

Although mechanical restraint is seldom used in the hospital environment, leather restraints are put on the class 1A patient when he is to travel by aircraft in order to insure his safety. The restraints are applied after the patient is placed on the litter and given a sedative.

a. Restraint Equipment (fig. 2). The equipment consists of 2 leather wristlets, 2 leather anklets, 2 leather straps, and 1 restraint key.

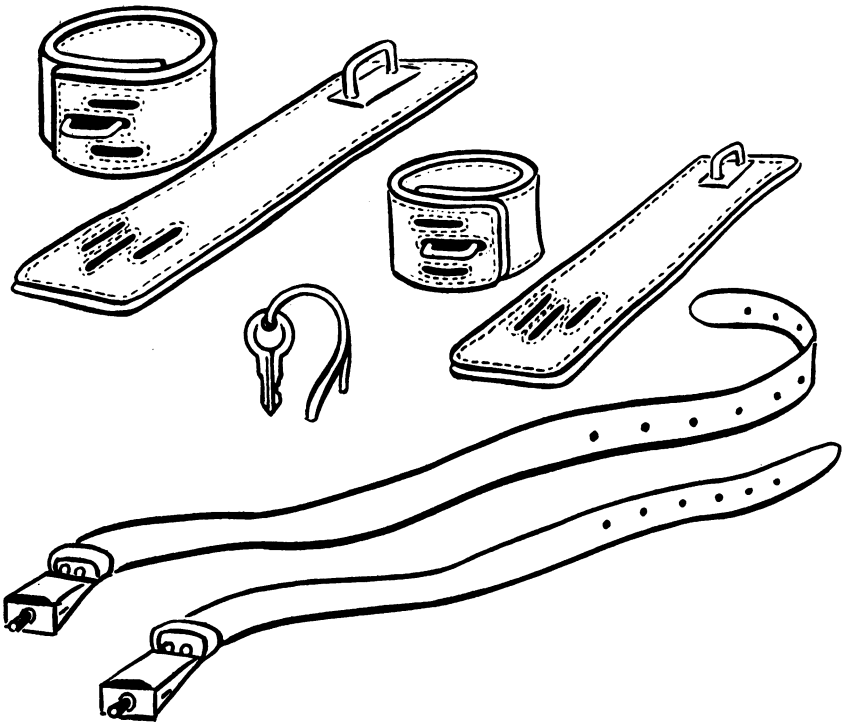


Figure 2. Leather restraints.

b. Procedure (fig. 3). The reason for using the restraints is first explained to the patient; then they are applied as follows:

(1) The wristlets are placed around the wrists; the leather strap is then slipped through the hook on each wristlet and around the body and buckled.
(2) The anklets are applied in the same way.
(3) Care is taken to be sure that the restraints are as comfortable as possible and that they do not interfere with circulation.
(4) The restraints are locked with the key, which accompanies the patient.
(5) The sheets and blankets are placed over the patient as prescribed (par. 145*b*(6)).

c. Care of Patient in Litter Restraint. After a patient is placed in litter restraint, he requires constant attention because he is completely helpless. He must be made as emotionally and physically comfortable as possible. He is allowed to smoke and to move his hands as much as is safe. The litter is moved with care to avoid bumping or frightening the patient.



Figure 3. Leather restraints applied.

CHAPTER 8

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Section I. PSYCHIATRIC EXAMINATION

147. General

Shortly after admission the patient undergoes a thorough physical examination during which time the psychiatrist makes an estimation of his mental illness. He then orders other studies such as psychological tests, electrocardiogram, and X-ray if he feels them to be necessary. The patient is usually quite concerned and anxious about the various procedures, particularly the patient who has never experienced such an examination. He ordinarily shows his anxiety by asking numerous questions about the procedures.

148. Responsibilities of the Specialist

The specialist is responsible for helping the patient overcome his fears about the examination. He does this by letting the patient know that he understands his feelings and by answering his questions with simple explanations.

Section II. LUMBAR PUNCTURE (SPINAL TAP)

149. General

A lumbar puncture is a procedure used to gain access to the spinal canal for the purposes of measuring spinal fluid pressure, removing spinal fluid from the canal, and injecting substance into the canal. Spinal fluid pressure is measured for possible elevation, which is a symptom of some diseases and injuries. Spinal fluid is removed from the canal to relieve pressure caused from elevation or to examine it for organisms of disease. Medication, such as anesthetics and antibiotics, are injected into the canal for treatment purposes; air or radiopaque medium is injected into the canal to make abnormalities visible in X-rays.

150. Preparation for Spinal Puncture

a. The Patient. The specialist helps prepare the patient physically and psychologically for a spinal puncture. Although the physician or nurse explains the purpose and process for a spinal

puncture to the patient, he may not completely understand or remember the explanation given him. The specialist is, therefore, prepared to answer the patient's questions and to give him further explanation if necessary. He carries out the physical preparation of the patient according to the physician's orders. The orders vary according to the purpose for the spinal puncture.

b. The Equipment. If the spinal puncture is to be performed in the X-ray department, the responsibility for having the required equipment available rests with this department. When the spinal puncture is to be performed in the neuropsychiatric department, the specialist procures the necessary equipment and sets it up in the treatment room according to the prescribed procedures. He procures a lumbar puncture tray, containing the necessary sterile items, from the centralized materiel section and obtains the following items from the ward:

(1) Skin preparation tray.
   (*a*) Soap solution and sponges.
   (*b*) Razor with blade.
   (*c*) Alcohol sponges.
   (*d*) Merthiolate.
   (*e*) Forceps in container.
(2) Sterile gloves.
(3) Adhesive tape.
(4) Procaine solution, 1 percent.
(5) Medication as ordered.
(6) Labels, small gummed.
(7) Standard Form 514h, Spinal Fluid, in triplicate.

151. Spinal Puncture Procedure

a. When the spinal puncture is performed in the treatment room, the specialist escorts the patient there and places him in the proper position. The spinal puncture may be performed with the patient in a lying or sitting position. In either position the patient's back must be curved as much as possible in order to enlarge the space between the vertebrae for insertion of the spinal needle. If the lying position is used, the patient is placed on his side with his back near the edge of the bed or table. His back is curved by drawing his knees up as far as possible and flexing his head and shoulders forward. If the sitting position is used, the patient may sit on a table with his head down and his knees clasped with his hands; or he may straddle a chair, facing its back, with his back arched and his chin on his chest.

b. During the spinal puncture procedures the specialist assists the patient to maintain the proper position and gives the physician

any assistance that he requests or requires. For further information regarding the spinal puncture procedure, see TM 8–230.

152. Spinal Puncture Preparatory for X-rays

When the spinal puncture is performed in the X-ray department for the purpose of making a pneumoencephalogram or myelogram, the specialist escorts the patient there. He may remain with the patient to give any reassurance and encouragement that he may need. He does not usually assist with the procedure.

a. Pneumoencephalogram. A pneumoencephalogram is an X-ray of the skull taken immediately after measured quantities of spinal fluid have been replaced with air by means of a spinal puncture. The air, being lighter than the fluid displaced, rises into the ventricles of the brain. The air, which is of less density than the brain and fluid, shows in the X-ray as a dark shadow, outlining the ventricles. Any abnormality, such as brain tumor, which changes the contour of the ventricles can thus be detected in the X-ray.

b. Myelogram. A myelogram is an X-ray of the spine taken after a contrast medium has been injected into the spinal canal by means of a spinal puncture. The contrast medium shows in the X-ray, making it possible to detect a lesion such as a tumor or a protruding intervertebral disc that may be causing pressure on the spinal cord.

153. Care of Patient After Spinal Puncture

a. The physician may want the patient who has had a spinal puncture to be up and around, or he may want him to have complete bed rest for a period of time. The specialist gives the patient the care prescribed by the physician and reports any complaints of the patient to the nurse.

b. After the pneumoencephalogram procedure the patient may experience discomfort and need close observation for a period of time. The physician's orders usually indicate complete bed rest for a period of 24 to 72 hours, medication for headache, instructions regarding nutrition, and frequency for taking temperature, pulse, respiration, and blood pressure. The specialist gives the patient the care prescribed and observes him closely for any symptom of shock such as faint feeling and decrease in pulse, respiration, or blood pressure. If any symptom occurs, he reports it to the nurse immediately.

c. The patient may also experience discomfort and need close observation following the myelogram procedure. The physician prescribes the care that the patient is to receive. He usually pre-

scribes complete bed rest for a period of time. When the radiopaque medium is not removed, the physician orders that the patient's head be kept elevated above the level of his spine. This is done to prevent the opaque medium from gravitating to the brain and irritating the meninges. The specialist follows the physician's orders, observes the patient for symptoms of meningeal irritation, which are primarily headache and stiff neck, and reports all symptoms and complaints to the nurse.

154. Care of Equipment After Spinal Puncture

If the spinal puncture is performed in the treatment room of the neuropsychiatric department, the specialist is responsible for the care of the equipment after it has been used. He washes and returns the equipment obtained from the centralized materiel section. He cleans the ward equipment and stores it in the proper place. Before handling equipment which has become contaminated with infectious material, he obtains instructions from the nurse for disinfecting it. Methods for disinfecting various kinds of equipment are explained in TM 8–230.

Section III. ELECTROENCEPHALOGRAM

155. General

a. Electroencephalogram (EEG) is a graphic record of the electric impulses which arise from the cortex of the brain in rhythmic waves. The EEG is used to aid in the diagnosis of epilepsy and to locate brain tumors and other brain lesions.

b. The EEG is made with a special apparatus called the electroencephalograph. The electric impulses of the brain are picked up by electrodes which are small flat metal discs attached to enamel wires. The disc ends of the electrodes are affixed to the patient's scalp, and the other ends are connected to the machine which records the impulses with a pen on a moving tape. The recording is made in a laboratory specifically equipped to eliminate noise and electrical interferences.

156. Preparation of the Patient

a. The patient may be extremely fearful of having an EEG made. He may have the mistaken impression that the electric current will pass through his brain. The specialist helps to alleviate the patient's fear by explaining to him in a simple way why the procedure is both painless and harmless.

b. The patient is prepared for an electroencephalogram in accordance with orders based upon the local hospital policy. Gen-

erally, the orders state (1) that no sedative or alcohol will be given the patient for several days before his appointment, (2) that during the evening before the appointment the patient's hair will be shampooed to remove oils and lotions, and (3) that the patient who is to have a *sleep EEG* will be kept awake the entire night before his appointment.

157. Procedure

The neuropsychiatric specialist escorts the patient to the laboratory and remains with him. The patient is told to lie on the bed where he remains throughout the procedure. A specialist who is trained in electroencephalography cleanses the scalp areas where the electrodes are to be placed with a solvent and applies a small amount of electrode paste. He then affixes the disc ends of the electrodes to the scalp with collodion and attaches the wires to the machine. Before the specialist turns on the machine, he encourages the patient to relax and refrain from even the slightest movement or noise while the recording is being made, as the least activity can cause a change in the type of waves. (For detailed information regarding the EEG procedure, see the instructional manual provided by the company which manufactured the particular machine in use at the hospital.)

158. Care of Patient After EEG

The specialist returns the patient to the ward and shampoos his hair to remove the electrode paste. He permits the patient who has had a *sleep EEG* to sleep if he desires.

Section IV. CHEMOTHERAPY

159. General

Chemotherapy is the treatment of illness by the administration of drugs. The most commonly used drugs in the treatment of psychiatric patients are those classifid as tranquilizers, stimulants, and sedatives.

160. Tranquilizers

a. General.

(1) *Tranquilizer* is a popular word for the professional term *ataractic,* meaning *freedom from disturbance.* The tranquilizing drugs were first used in the treatment of psychiatric disorders in France and India. In 1954 they were introduced in the United States. Since that time, hundreds of different kinds of tranquilizing drugs have been produced.

(2) The psychiatrist determines whether or not a patient should receive tranquilizing drug therapy and selects the type of tranquilizer which is best for the patient according to his age, condition, severity of symptoms, and response. He prescribes the minimum dosage which will control the patient's symptoms and determines when the therapy is to be discontinued or continued for a prolonged period of time.

b. Therapeutic Action. Tranquilizers calm the patient by relieving his anxiety; they give him relief from distressing symtoms such as anguish, bitterness, hostility, and despair without clouding his consciousness. He is, therefore, alert and better able to face, discuss, and work through his problems with the help of the psychiatric team. He is more receptive to therapeutic guidance, more capable of forming relationships with other persons, and better able to control his behavior. The agitated, irritable patient frequently becomes quiet and cooperative. The patient with assaultive and destructive tendencies may become interested in constructive activities. The patient who has been soiling himself may stop doing so. The emotional content associated with hallucinations and delusions is lessened. With the patient relieved of his distressing symptoms and more receptive to help, the psychiatric team members are able to apply their efforts more directly toward the patient's recovery.

c. Side Reactions. Tranquilizers may produce side reactions which complicate their use. Some of the possible mild reactions are temperature as high as 101° F., swelling of the face and feet, drowsiness, weakness, nausea and vomiting, diarrhea, nasal congestion, salivation, slightly lowered blood pressure, and mild dermatitis. A patient's skin may become extremely sensitive to bright light and easily burned, making it necessary to prevent exposure to the sun. Only in a small percentage of cases do patients have severe reactions to tranquilizers. When a severe reaction occurs, the medication is usually adjusted downward or discontinued. The following reactions are considered serious:

(1) Severe allergy—severe skin rash or hives.
(2) Jaundice—yellow tone to the skin and to the sclera caused by liver malfunction.
(3) Parkinson's syndrome—uncontrollable movements of voluntary muscles characterized by twitching and rigidity of muscles; disturbance in gait, most frequently a shuffling gait; and excessive salivation.
(4) Agranulocytosis—change in composition of blood, causing the patient to be more prone to sudden onset of sore throat and gums.

(5) Depression—sudden onset of depression or increased depression.
(6) Severe hypotension—severe low blood pressure for a prolonged period.
(7) Convulsions—involuntary, violent muscular contractions.

d. Contraindications. Patients may have contraindications to tranquilizers. The patient whose blood pressure is dangerously low is not given the kind of tranquilizer which lowers blood pressure. The patient with a duodenal ulcer is not ordinarily given tranquilizers because they increase gastric secretions. Since tranquilizers may produce a temporary liver involvement, they are not prescribed for a patient with jaundice or other liver disease. Of course, an unconscious patient is not given drugs of a tranquilizing nature.

e. Responsibilities of the Specialist.

(1) *Administering tranquilizers.* Under guidance of the nurse, the specialist assists in administering tranquilizers. The drug may be administered orally or intramuscularly. The specialist takes the precautions essential in administering any medication (par. 84*b*(5)). He also has the patient lie down for at least thirty minutes to reduce the likelihood of postural hypotension—a low blood pressure resulting from a sudden change in posture. When the patient takes the drug orally, this precautionary measure usually becomes unnecessary after the first few doses. The specialist observes the patient for symptoms of postural hypotension: pallor, dizziness, weakness, lowered blood pressure, and a rapid, thready pulse. If such symptoms occur, he raises the patient's feet higher than his head to restore sufficient blood flow to the brain. Any time a patient refuses to take tranquilizers, the specialist tries to learn the reason, as the patient's feelings regarding the value of the medication affect the therapeutic benefit which he receives from it. (For explanation of procedure used in administering drugs intramuscularly, see TM 8–230).

(2) *Observing and reporting reactions to tranquilizers.* The most important single responsibility of the specialist in the care of the patient who is receiving tranquilizing drugs is the accurate observation and reporting of responses and side effects which the drugs may produce. Such information is very valuable in determining the kind of tranquilizer and dosage which are best for the individual patient and in effectively adjusting the therapeutic plan according to his reaction to the drug.

(3) *Providing therapeutic guidance.* The specialist takes advantage of the patient's calmness and receptiveness to give him therapeutic guidance. He encourages the patient to improve his personal appearance and to assume more responsibility for his own physical care. He gets the patient interested in activities in which he can experience success, encourages him to socialize, and helps him to re-establish social skills. In guiding the patient into these activities, he watches for any unfavorable drug reactions the patient may have.

161. Stimulants

a. General. Stimulants are the psyche-energizers and antidepressant drugs. They are administered to give patients relief from symptoms of mental and emotional distress characterized by discouragement, apathy, depression, fears, irritability, sensations of exhaustion, and undue preoccupation with vague somatic complaints. The patient becomes more wakeful, alert, talkative, optimistic, and confident; and his fatigue diminishes.

b. Responsibilities of the Specialist. The responsibilities of the specialist are generally the same in stimulating drug therapy as in tranquilizing drug therapy. He observes the patient for possible side reactions such as weakness and dizziness, hot and cold sensations, dryness of the mouth, palpitations, headaches, restlessness, and insomnia. He reports to the nurse any side reactions and the patient's responses to the drug.

162. Sedatives

Sedatives are drugs which produce rest, sleep, or a lowered state of consciousness. In the treatment of psychiatric patients these drugs are used for sedation and for reducing an emotional block.

a. Sedation. Sedation is a means of calming the patient by putting him to sleep or producing drowsiness. It is used to give the patient temporary relief from severe anxiety reactions, thereby providing him rest from his problems. It is also used to insure sleep for the patient who suffers from insomnia.

b. Sodium Amytal Interview.

(1) The sodium amytal interview is a narcosis technique which the psychiatrist may use to reduce a patient's emotional block against expressing his feelings and thus secure sufficient response to enable him to discover the emotional problems leading to the patient's illness. Although the slowly acting sedative, sodium amytal, is used

most frequently for this purpose, other sedatives may also be used. The sedative is injected very slowly into the patient's vein until he becomes drowsy but not stuporous. This is a lowered state of consciousness midway between being awake and asleep. The patient is recognized to be in this state when he begins to have difficulty in counting from one to ten. At this level of consciousness the patient responds to questions because inhibitions are released and suppressed thoughts and feelings are brought into consciousness. With the patient's psychological resistance thus temporarily reduced, the psychiatrist is usually able to seek out the underlying conflicts.

(2) When the psychiatrist orders such an interview, the specialist who is to assist him must see that the following equipment is ready:

(*a*) Syringe—300cc.
(*b*) Two needles—No. 22 gauge.
(*c*) Tourniquet.
(*d*) Alcohol sponges.
(*e*) Ampule of sodium amytal—7½cc.
(*f*) Ampule file
For emergency use:
(*g*) Stimulant tray.
(*h*) Blood pressure apparatus.

Section V. ELECTROCONVULSIVE THERAPY

163. General

a. Electroconvulsive therapy (ECT) is a treatment in which unconsciousness accompanied by a generalized convulsion is produced by transmitting electrical current to the patient's cerebral cortex through electrodes placed on his temples. This effect is obtained by applying 70 to 130 volts of electric current for a period of 0.1 to 0.5 seconds. The patient feels no pain, as he loses consciousness immediately. He remains unconscious for several minutes. Why this treatment helps patients with certain mental illnesses is not known. A commonly accepted theory is that the unconscious state and central nervous system activity serve to break the patient's pattern of disordered thinking, thereby making him better able to re-establish contact with reality and, therefore, more accessible to psychotherapy and therapeutic guidance.

b. The electroconvulsive treatment may be modified through the use of drugs which suppress the generalized convulsion and reduce the convulsive activities to twitching of the fingers and

toes and temporary cessation of respiration. This modified form of treatment allows all the central nervous system features of a convulsion to take place while markedly reducing the actual muscular spasms. It is particularly useful with the patient whose physical condition is such that the regular treatment is contraindicated.

c. The patient is ordinarily given electroconvulsive therapy every other day, three times a week. He may be given the treatment more or less often, depending upon his condition. The number of treatments which he receives depends upon his individual response. Most patients receive between six and twenty treatments.

d. The psychiatric examination given the patient soon after admission reveals the patient's physical state of health and enables the psychiatrist to determine the feasibility of giving him electroconvulsive therapy. When necessary an electroencephalogram and electrocardiogram are made to aid the psychiatrist in making this determination. The patient's progress and physical condition are evaluated throughout the course of treatment.

164. Electroconvulsive Therapy Unit

The electroconvulsive therapy unit consists of the waiting room, treatment room, and recovery room.

a. The waiting room is located sufficient distance from the treatment room to prevent the patients who are waiting for treatment from seeing or hearing the patient who is having treatment. This not only preserves the dignity and self-respect of the patient during treatment but also helps to prevent his becoming fearful while he is waiting for treatment. The specialist makes certain that the waiting room is pleasant, clean, and well-ventilated and that it is furnished with facilities appropriate for keeping the patients occupied and relaxed. These facilities ordinarily include such items as comfortable chairs, radio, television, magazines, playing cards, and other games.

b. The treatment room is set up with all equipment necessary for administering electroconvulsive therapy and for giving emergency treatment. Careful consideration is given to the safety factors. The specialist insures that all equipment and supplies noted on the check list in the treatment room are available and in good condition. The check list ordinarily includes the following items:

(1) Table or stretcher with a rubber covered mattress.
(2) Pillows or sand bags.
(3) Rubber or gauze mouth gags.

(4) Hypodermic tray with drugs as ordered.
(5) Oxygen.
(6) Suction.
(7) Saline solution.
(8) Electrotherapy machine. This machine, approximately eighteen inches square, regulates the voltage and duration of the electric current. A variable transformer within the machine changes the ordinary 110-volt alternating current used in lighting to the voltage desired. A timing device interrupts the current at the desired time.

c. The recovery room is ordinarily a small ward. The specialist assures that it has a quiet, comfortably cool, softly lighted environment conducive to sleep. He prepares the required number of beds, always placing a rubber sheet between the mattress and cloth sheet; supplies sufficient pillows to cushion any surface which could cause injury; and attaches side rails to the beds, if necessary.

165. Preparation of the Patient

a. Preparing the patient psychologically is an essential part of electroconvulsive therapy because the patient is usually fearful of this treatment. He may fear the treatment because it is electrically induced, because he will become unconscious, or because he believes that he will experience severe pain. The psychiatrist first explains the treatment to the patient in simple terms and encourages him to cooperate. The specialist reinforces the psychiatrist's explanation as the patient asks questions or shows concern about the treatment. He assures the patient that he will feel no pain and aids him in understanding why it is important that he cooperate. He observes the patient closely throughout the series of treatments and gives him emotional support.

b. On the day that the patient is to receive treatment, the specialist prepares him physically. This includes omission of the last meal prior to treatment; check of temperature, pulse, respiration, and blood pressure (TM 8–230); toileting; oral hygiene; removal of dentures, gum, or any other objects from the mouth; and removal of spectacles, contact lenses, and any other prosthesis.

c. The specialist escorts the patients to the waiting room. Here the specialist attempts to create an atmosphere which lessens fear, tension, and anxiety. He maintains a matter-of-fact approach to the impending treatment. He gets the patients interested in activities and guides their conversation into diverting topics. He reports to the nurse any behavior which indicates that a patient is not emotionally prepared for the treatment.

166. The Treatment Process

a. The patient is placed on the treatment table with pillows under his legs and back. His person is rechecked for any prosthesis such as dentures or contact lenses. His temples are cleansed of skin oil and the electrodes, which have been soaked in a saline solution to insure electrical contact, are applied to these areas. In order to prevent fractures and dislocations by convulsive movements, the specialists take positions which will enable them to support the patient's jaws, shoulders, arms, and legs. A mouth gag is placed between the patient's teeth to prevent injury of the tongue and teeth. When the current is applied, the patient loses consciousness and stops breathing. This signals the tonic phase of the convulsion which lasts from 10 to 20 seconds. During this time the patient is rigid; his trunk, legs, arms, and hands are in a half-flexed spasm. His face is pale, his lips are blue, his pupils dilate, and his eyes roll upward. During the clonic phase which follows and lasts from one to three minutes, there is a relaxation of muscles followed by alternating rigidity and slackness of the muscles. The patient usually starts breathing noisily and may froth at the mouth. The patient is turned on his side to aid the flow of saliva from his mouth. If breathing does not begin spontaneously within a few seconds after the convulsive movements subside, the patient is given oxygen or stimulant drugs. As soon as the patient is breathing regularly, he is taken to the recovery room.

b. When the modified treatment is used, an anesthetist is present to administer the prescribed medication before the treatment. Since the medication reduces the convulsive movements, the physical support activities of the specialists during treatment are altered to meet the individual response of the patient. Following the treatment, the anesthetist administers oxygen and takes whatever other action may be required to reinstate breathing; respiration is not resumed spontaneously because of the relaxed state of the muscles. When regular respiration is established, the patient is taken to the recovery room.

167. Care of Patient After Treatment

In the recovery room the patient is carefully moved from the stretcher to a bed. He is placed on his side to facilitate drainage of saliva from his mouth. A specialist remains with the patient and observes him closely while he is recovering from treatment. It ordinarily takes 15 to 30 minutes for the patient to get fully awake. As soon as the patient's jaws relax, the specialist removes the mouth gag. If the patient becomes restless or hyperactive, he

protects him from injury. When the patient first awakens, he is usually semi-stuporous, drowsy, dizzy, and confused. He frequently complains of amnesia (inability to remember), headache, and generalized muscular soreness. The specialist reassures the patient that his amnesia is only temporary. He reports all physical complaints, regardless of how trivial, to the nurse. As soon as the patient is able to respond and his dizziness subsides, the specialist helps him to shower, dress, and eat. During the first several hours following recovery from the treatment, the patient is more relaxed and amenable to suggestions. The specialist takes advantage of this period to get him interested in participating in the planned ward activities.

Section VI. INSULIN THERAPY

168. General

Inasmuch as insulin therapy requires a longer period of time than the psychiatric patient remains in an Army hospital, it is seldom used. For this reason, insulin therapy is discussed only briefly in this manual.

169. Insulin Coma Therapy

Insulin coma therapy is a treatment in which a large dose of insulin is injected intramuscularly for the purpose of producing hypoglycemia (deficiency of sugar in blood) to a degree that results in loss of consciousness. The unconsciousness or coma is terminated by the intravenous administration of glucose followed by oral intake of additional glucose. A series of insulin treatments bring about varying degrees of change and improvement in patients with schizophrenic reaction, especially the paranoid type. Insulin therapy seems to break through the patient's psychotic pattern, enabling him to establish contact with those about him. Although these periods of contact with reality may be brief at first, they become increasingly longer as the course of treatment progresses, making the patient more accessible to psychotherapy and therapeutic guidance.

170. Insulin Subcoma Therapy

Insulin subcoma therapy is used primarily as a supportive measure for mild psychiatric disorders. The patient is given the amount of insulin which will produce hypoglycemia without unconsciousness. The reaction is terminated by having the patient drink a glucose solution. This treatment helps to reduce anxiety and overactivity, thereby making the patient more accessible to other therapeutic efforts.

Section VII. PSYCHOTHERAPY

171. General

a. Psychotherapy is a psychological method of treatment directed toward helping the patient to overcome emotional and personality problems and disorders. The specific aims of this therapy depend upon the needs of the patient and the therapeutic facilities available. The general aims are to help the patient to—

(1) Increase self-understanding and awareness of the meaning and purpose of his behavior.
(2) Increase self-acceptance and a feeling of personal worth and adequacy.
(3) Replace unacceptable personality characteristics with behavior patterns which are more effective in coping with problems that arouse anxiety and which are socially acceptacle and conducive to satisfactory interpersonal relationships.
(4) Rid himself of anxieties and fears which have interfered with and reduced his efficiency in performing the normal functions of everyday life.
(5) Reduce emotional stresses and develop the ability to face new situations objectively and with emotional maturity.

b. The procedures of psychotherapy are ordinarily referred to as individual therapy and group therapy. Individual therapy is more effective in working through deep conflicts; whereas group therapy is particularly valuable in promoting an understanding of existing problems.

172. Individual Psychotherapy

a. General.

(1) When the therapist treats only one patient at a time, the procedure is referred to as individual psychotherapy. The effectiveness of this procedure depends primarily upon the patient-therapist relationship. In being accepting and permissive, the therapist establishes a relationship which enables the patient to discuss his deepest conflicts and problems without fear of judgment, retaliation, or punishment. Such a relationship is a necessary prerequisite for emotional participation of the patient.
(2) There are many types and forms of individual psychotherapy. The supportive type is ordinarily used in military hospitals.

b. Supportive Therapy. In the military the objective of supportive therapy is to return the patient to duty or civilian life in

the best possible state of health so that he can again function at his optimum level. Supportive therapy is designed to help the patient modify attitudes which disturb his relations with other people or create anxiety within himself to such a degree that he is unable to carry out his daily tasks. Actually, it is a re-education process aimed at helping the patient to change attitudes which have been warped by resentment, guilt, hostility, frustration, overambitiousness, or depression. Through ordinary conversations directed toward definite problem situations, the therapist encourages the patient to talk spontaneously about his feelings and problems and to explain specific circumstances under which his difficulties first appeared. During these conversations the therapist attempts to help the patient to understand his attitudes and reactions to these problem situations and to establish a more rational, constructive, and realistic approach to them. In this type of therapy the therapist does not attempt to get the patient to analyze unconscious attitudes and mechanisms which led to his illness.

173. Group Psychotherapy

a. Group psychotherapy is a procedure used to produce therapeutic benefits through group participation. Patients who have similar problems are assembled in an informal setting and skillfully guided by a professionally qualified person in the discussion of their conflicts, concerns, and worries. They share puzzling questions concerning their experiences and difficulties and attempt to arrive at an understanding of them. Patients who feel threatened by individual psychotherapy often find in such a group the acceptance and support necessary for the examination of their problems.

b. One of the most valuable benefits of group psychotherapy is the patient's realization that he is not alone in having problems and that other patients experience similar feelings and attitudes. For example, guilt feelings are often reduced by learning that others have similar reactions. Group psychotherapy helps the patient gain insight into the reasons for his problems, thereby enabling him to learn and understand how to change his behavior. For example, through group discussions of a patient's problem and associated hostile feeling, the patient attains a broader outlook concerning the situation, thus helping him to see it in a different light and to handle his negative feelings in a more acceptable, constructive way. Since this type discussion is not only stimulating but infectious, the withdrawn patient tends also to voice his problems and feelings. The feeling of group identification combined with feeling of belonging helps the patient develop habits

acceptable to group living. He learns to work effectively with a group toward helping himself and others to attain the desired goal, thereby enhancing his chances of adjusting to organized military life. The greatest value of this particular therapy, however, is gained from the ventilation of pent-up feelings through participation in an atmosphere which is accepting.

174. Responsibilities of the Specialist

The specialist must be aware of the facts that the patient has many reactions and responses to psychotherapy and that the patient's attitudes and behavior change as psychotherapy opens up areas which provoke thought and make him feel, for example, anxious, guilty, or uncomfortable. Sometimes a patient reacts to such feelings immediately after he returns to the ward from a session with the therapist. For example, he may cry or express hostile feelings, frequently toward the therapist. It is important for the specialist to realize that such a reaction does not indicate harmful therapy session. He can best benefit the patient by accepting his reaction in a matter-of-fact manner and by getting him interested in some constructive activity. At times the patient may become discouraged; he may feel that the psychotherapy is harming rather than helping him if, for example, his emotions lessen his effectiveness in activities or he encounters new problems in an attempt to deal with life more realistically. Through sincere expressions of confidence in psychotherapy and encouragement, the specialist helps the patient through these periods. He shows interest in the patient's problems by listening attentively but never attempts to counsel him because such counseling could be contrary to the aims of the therapist. He encourages the patient to discuss his problems and feelings with the therapist. As psychotherapy progresses, he serves as a person on whom the patient can practice newly acquired social skills, thereby increasing selfconfidence and his feeling of security.

CHAPTER 9

COMBAT EXHAUSTION

Section I. INTRODUCTION

175. A Combat Exhausted Casualty

a. In July 1952 at the height of the hill fighting in Korea, a 22-year old private stumbled into a medical aid station. His helmet and rifle were gone. He stared into spare, jumped at the slightest noise, and sobbed hysterically when anyone spoke to him. "I can't take it," he said. "These hills have got me . . . dead guys everywhere . . . those three guys in my squad . . . everyplace I go, it's like this . . . can't do it any more." What remained of his platoon had just been ordered off Hill 266, "Old Baldy," a battleground raked by savage enemy shellfire for a week.

b. This soldier was a combat exhaustion casualty, one of the hundreds of U. S. infantrymen psychologically wounded in Korea. His wound was very real. It put him out of action for the duration of the war and required the time and attention of doctors and aid men. In terms of hours and effort spent, its impact on medical personnel was greater than that of a severe abdominal wound or a napalm burn.

176. Scope of Combat Exhaustion

a. In modern warfare one of every five casualties is a combat exhaustion case. Considering the hundreds of thousands of front-line soldiers involved in a major conflict, this statistic represents an immense number of men. During World War II, 750,000 psychiatric casualties were admitted to Army hospitals. This figure does not include the innumerable soldiers who received therapy at aid stations and went back to combat. For psychological injuries suffered in World War II and Korea, more than one-half million ex-soldiers were granted disability compensation. Combat exhaustion can be a vast area of military manpower loss.

b. An awareness of the size of the combat exhaustion problem has led to major recuperative steps in recent years. While less than five percent of all psychiatric casualties in the North African campaign of World War II were salvaged for combat, approxi-

mately sixty percent were returned to the front in Korea. This progress indicates that combat exhaustion, as large a problem as it is, can be handled.

177. Normal Reaction to Combat

If the going gets tough enough, almost everyone in a combat situation will feel profound fear. The American soldier certainly is not immune to it. He has grown up in a society opposed to violence and militarism; survival has never been a problem for him. But on the battlefield he is a target, a combatant whose enemies are out to destroy him. Suddenly, his own job is to kill. Although he was able to handle most civilian problems, the battlefield is a new and gigantic threat. His ordinary civilian adjustments will not work in combat. There is no getting out, no easy change of location, or no telephone call to say he cannot make it. There is no assurance that he will even be around tomorrow. To him physical danger seems to be the only sure thing. The soldier wants to live. If he knows where he is and is logical, he realizes that the battlefield cuts to the minimum his chances of staying alive. Fear is his first reaction.

Section II. COMBAT STRESSES

178. General

Extreme fear is only one reaction experienced by the soldier in battle. Many stresses—conditions demanding new adjustments—cluster around the central fear of death. These stresses fall into physical and psychological categories.

179. Physical Stresses

a. Physical stresses are always present in combat. They hammer at the frontline soldier for days and sometimes weeks, making his life an endless series of shocks and emergencies. His routine of eating and sleeping is totally disrupted. He may go without food for 24 hours and be forced to remain awake for 2 or 3 days. His shelter is usually inadequate; he may be rain-soaked, frostbitten, or sun-parched, depending on the theater of operations. His clothing is probably torn and dirty; his boots are likely falling apart; his personal hygiene opportunities are practically nil. He may be wounded physically; if so, he has probably lost blood. His muscles are likely "dead" from exertion. He may be suffering from diarrhea or malaria. His hearing is usually distorted by compression waves and the rattle of small arms fire. He is in a state of acute physical discomfort, and he probably will be as long as he stays in combat.

b. The immediate physical discomfort in combat, however, may not be as difficult for the American soldier to tolerate as the absence of civilian comforts. His shower, cigars, desserts, soft bed, and 8-hour job, as well as other things that made his civilian life livable, are far away. If he could have these creature comforts to fall back upon once in awhile, he might be better able to tolerate the physical discomforts of combat. But to the first-line soldier, these comforts seem to be gone forever, leaving him less resistant to stress in general.

180. Psychological Stresses

a. Psychological stresses in combat undermine fighting efficiency as surely as starvation or subzero temperatures. These stresses stem in one way or another from the fear of death. In the mind of the soldier, this fear often grows into a conflict—a head-on collision of opposite desires. He wants to run, to save himself, to get as far as possible from the danger; but his conscience, a complex and powerful force, tells him to stay in his foxhole. His conscience has been a part of him almost as long as he can remember. As a child he was taught to believe in the idea of loyalty. He reinforced this idea by developing close friendships, playing on teams, and running with a certain gang. He learned to stick with his friends and to see himself as part of something larger. At the same time, his ideas of patriotism were taking shape. He began to identify himself with his country; her problems and triumphs became his. The soldier, in the forced brotherhood brought on by combat, attaches his loyalty to his fighting unit. He cannot run out on his buddies. His unit needs him. His platoon leader is counting on him. Most of the time these demands of the soldier's conscience are strong enough to offset his fear and to keep him in his position; but the desire "to get out" is still there. Because of this conflict, the stress on the soldier is all the heavier.

b. Another conflict, wishing for a "million-dollar wound" but fearing its consequences, also produces severe stress. The soldier wants out; but he wants to exit gracefully, without losing prestige or glory. A wound would solve his problem; but the wound would hurt and might blind, castrate, or even kill him.

c. Any of a number of other psychological stresses may weaken the individual soldier. His resistance may be low because of four unrelieved months at the front. Home problems—a sick father, a Dear John letter, or a failing business—may have him in a state of depression. If his unit is retreating, he probably has some doubts about the final outcome of the war. Rumors make him

apprehensive and hesitant to invest any more of himself in a losing cause. A battlefield demotion or promotion can dislocate his whole outlook on combat. A friendly gesture by the enemy may make him question the need for risks and violence. The sight of a mutilated child, the death of his platoon leader, an unexpected switch in orders, or a command that seems suicidal can also carry a full charge of stress.

Section III. REACTIONS TO STRESSES

181. Anxiety

Stress triggers a reaction called anxiety—a state of general tension and apprehension. Anxiety, unlike fear, is not the result of any one particular threat. It is vague and free-floating. The symptoms of anxiety are both physical and psychological.

a. Physical Effects. One of the first physical signs of anxiety in combat is increased muscle tension: the soldier's hands tremble and his muscles knot up with cramps. At the same time, he sweats heavily and needs to urinate several times every hour. His heart flutters; his appetite disappears; he may suffer from either diarrhea or constipation. These physical effects leave him more exposed to further emotional stresses.

b. Psychological Effects.

(1) The psychological effects of anxiety depend upon the soldier's degree of resistance to stress. Each soldier's emotional reaction to combat is unique. Although every combat soldier experiences anxiety, the soldier with unusually strong resistance may take the full intensity of combat stress without being shaken. Another soldier may withstand severe stress for months before he breaks. At a certain point, he cannot take the pressure any longer. A less resistant soldier may not even feel the minor stresses but may suddenly fall apart under intense pressure. The emotionally weak soldier may not be able to tolerate even the minor stresses. Combat is a tougher emotional challenge than he can handle, but he can be a valuable member of the fighting team in a less stressful situation. A breakdown in battle, then, depends upon two factors: the intensity of the stress and the resistance of the individual.

(2) Increasing irritability is usually the first psychological sign of anxiety. It may be shown by angry looks, snappishness, tears in response to minor frustrations, profane outbursts, or acts of violence. A soldier is usually

painfully aware of his decreasing self-control and is as much disturbed by it as by the consequences of his behavior. As one soldier said, "That guy's gum-chewing just bugged me and there wasn't anything I could do about it. All night in the trench he popped that gum. I took it as long as I could; then I hit him. I'm ashamed I did it, but I swear before God I couldn't stop myself. Right then I figured I had started slipping." Associated with this abnormal irritability is the startle reaction—a sudden, involuntary response to unexpected noises or movements. The person may leap, cringe, or shield himself with jerking movements. Sleep disturbances also go hand in hand with over-irritability. Since chances for sleep in combat are rare, it is highly frustrating to be unable to fall asleep or to remain asleep when the combat situation permits.

182. Modification of Anxiety

When routine anxiety situations go from bad to intolerable, various other reactions appear. A tank crewman's tension may suddenly blossom into an overpowering fear of landmines. For a foot soldier pinned down in a trench or bunker, the continuing roar of 88-mm artillery fire may bring on hysterical sobbing. A front line soldier who recognizes his fear and becomes morbidly ashamed of it may become crippled by guilt feelings. Guilt of another kind appears when a passive, retiring individual drives himself into aggressive behavior, later regretting it, or when he catches himself hating the platoon leader, the man who forces him into combat. These are only a few of the modified effects of combat anxiety.

Section IV. DEFENSE AGAINST ANXIETY

183. Artificial Supports

If a soldier is not able to handle the stresses of combat, he may try to master his anxiety by using artificial props to bolster his defenses. The performance of Indian soldiers in Korea is an example of this. Since a show of fear was culturally unacceptable to the Indian infantryman, he almost never displayed anxiety reactions. But the desire "to get out" was still there and showed up frequently as self-multilation, an "honorable" way of avoiding combat. American soldiers are not this worried about maintaining a rock-like exterior, but they often use unrealistic defenses. Some have the illusion of personal immortality—the idea that "they won't get me." Others who do not see themselves as indestructible

depend upon good-luck charms or the love of a sweetheart to pull them through. Many soldiers disguise their anxiety defenses with cold calculation: "Let's face it; the odds are against my getting hit. Even if my number does come up, it'll happen whether I'm here or somewhere else, so why worry."

184. Realistic Supports

a. Group Indentification.

(1) The greatest emotional support in combat is group identification. This means that the soldier equates himself with the group—his squad, platoon, or company. As home grows remote and the battlefield becomes terrifyingly real, the combat unit is the focus of the soldier's life. It protects him by its strength and numbers; and in a way it insulates him emotionally, since it gives him the only friendly human contacts possible under the circumstances. He shares in the successes and horrors of the unit; he feels its losses personally. He picks up its poses and lingo and identifies himself with its combat history. He seeks the unit's approval, even to the point of changing his personality. The fearful, passive soldier becomes aggressive because this is what the group wants. On the other hand, the self-sufficient soldier, finding himself in a tightly knitted group, is sure in the knowledge that he will not have "to go it alone." Thus, the combat unit gives both soldiers the stable emotional involvement they need: to give and to receive support. Sometimes the unit feeling that matures in combat is so strong that wounded soldiers ask to leave the hospital early to rejoin their battle groups. It is understandable why psychological breakdowns in combat so often follow a loss of group support.

(2) Evacuation, which robs a soldier of group identification, can cause serious psychological effects. The soldier may develop a feeling of guilt for having left his buddies at the front. To get relief from this feeling, he may develop physical ailments of strictly psychological origin. Although these physical ailments or secondary symptoms make him feel that he deserves evacuation, they hinder his recovery from the physical or psychological wound which caused him to be evacuated.

b. Leadership. Effective leadership is a strong emotional support for the soldier in combat. The squad or platoon leader can make or break the stability of his unit. He is somone the soldier can lean on and look up to. His orders give the group direction

and purpose, which strengthen group identification. The physical presence of the leader suggests to the men qualities of judgment and capability. They feel secure in the hands of a man who knows what he is doing. This helps explain why epidemics of psychological illness often hit a combat unit whose leader has been removed and not promptly replaced. A solid leader means vital emotional support in any battle situation.

c. Training and Discipline. Another important emotional support is proper training and discipline. The soldier who knows how to handle his weapons, protect himself, and respond to orders is usually too occupied with his fighting role to crack up psychologically. He knows the work which has been cut out for him; he fills his place on the combat team automatically. The undisciplined, carelessly trained unit is usually the first to fall apart emotionally. Its members are like amateurs in any other area; they "choke up" under stress.

d. Confidence in Purpose, Plans, Equipment, and Personnel.

(1) An army with a purpose is hard to stop. This is the key to the power generated in popular revolutions. When an army with a purpose also believes in its tactics and equipment, it becomes almost unbeatable, especially psychologically. Having a cause, an idea to believe in and fight for, is a great emotional support for the individual soldier. He fights well when he has something for which to fight. This "something" may be the preservation of his homeland or an abstract principle.

(2) The modern foot soldier knows that his survival depends on the other members of the fighting team. He may ask himself: Will air support come through in time for the attack? Will the artillery do its job? How well has the hill been scouted? Are supplies and replacements available? What tactics and maneuvers are to be employed? The soldier who has confidence that the other members of the fighting team will fulfill their roles is free from a heavy load of potential anxiety. Having this confidence strengthens his emotional resistance and enables him to concentrate on his own job.

Section V. RECOGNIZING COMBAT EXHAUSTION

185. Significance of Term "Combat Exhaustion"

The term "combat exhaustion" evolved through two world wars and appeared first as "shell shock," then as "operational fatigue," and later as "war neurosis." In 1943 "combat exhaustion" be-

came the official Army label for the combat psychiatric casualty. This term, which implies quick recovery, is descriptive of the combat psychiatric casualty; yet it is sufficiently nonspecific to be useful as a general diagnosis for all psychiatric casualties at the aid station level. Since trained psychiatrists are seldom available under battlefield circumstances to make precise diagnosis, this general diagnostic term is especially useful. Moreover, it is usually accurate, as the great majority of psychiatric casualties recover after getting sleep, hot food, and comparative security for several days. Since psychiatric casualties who do not recover within a few days are moved to psychiatric facilities farther in the rear and given a new diagnosis, the term "combat exhaustion" also distinguishes the temporary psychological illness caused by battle stress from long-term psychological symptoms aggravated by combat.

186. Types of Combat Exhaustion

Since combat exhaustion varies from exaggerated battle fear to complete breakup of the personality, it is classified mild, moderate, or severe.

a. Mild Combat Exhaustion. Seventy percent of all psychiatric casualties are diagnosed as mild combat exhaustion cases. The soldier in this category can no longer carry on as an effective fighting man even though his outward appearance may seem normal. He is physically worn out and depressed; he may be irritable and tearful. He often complains of physical pains which are disguises for his anxiety. He feels he has had all the combat stress he can tolerate.

b. Moderate Combat Exhaustion. Moderate combat exhaustion is the diagnosis for approximately 25 percent of all psychiatric casualties. It is much more disabling than mild combat exhaustion, as the soldier can no longer work effectively in any capacity, combat or otherwise. He is severely depressed, apathetic, and often guilt-ridden. He cannot make decisions. His anxiety may convert itself into a major physical symptom, such as blindness or paralysis.

c. Severe Combat Exhaustion. Only 3 to 5 percent of the psychiatric casualties seen at frontline aid stations have severe combat exhaustion. A soldier with severe combat exhaustion can no longer function as a human being because he has lost contact with reality. His behavior may be extremely bizarre. He may wave his hands violently and scream or run until he drops. He may sit speechless for hours, appearing to hear and see nothing. He feels that everyone is plotting against him and that everything

is a threat. He often hears the voices of God and dead friends. After he is evacuated from the combat situation the symptoms usually become less severe.

Section VI. TREATMENT OF COMBAT EXHAUSTION

187. Reason

Combat exhaustion saps the fighting strength of the Army. The Army Medical Service, organized to conserve the fighting strength, has the responsibility for overcoming this obstacle as rapidly and efficiently as possible. The main objective in treating combat exhaustion is, therefore, to rehabilitate the disabled man as soon as possible and get him back into action as an effective soldier. His unit needs him as a trained member of the fighting team, and he needs the unit as a support for his feelings of personal worth.

188. Principles of Treatment

In treating combat exhaustion, the Army psychiatric team follows five main principles. These principles, nontechnical and simple, are vital to the success of the therapy.

a. Treat as Early and Far Forward as Possible. Treating combat exhaustion as early and as close to the front as possible prevents the suggestion of serious disability which can lead to a feeling of hopelessness and a slow recovery. It also avoids, in the majority of cases, the necessity for evacuation, which disrupts the soldier's sense of group identity and often causes him to develop guilt feelings.

b. Rehabilitate Physically. To rehabilitate the soldier physically calls for the simplest kind of treatment. Temporary provisions are made for rest (with sedation if necessary), shelter, hot food, hot shower, shave, and change of clothes. Having these elements of comfort plus diversion from combat and needed firmness and understanding from the medical personnel, the soldier improves rapidly. The short break in combat duty gives him an opportunity to get back on his feet physically and at the same time to pull himself together emotionally.

c. Provide Opportunity for Ventilation. In the combat unit the soldier is usually hesitant to show his fear, imagining he will "lose face," but at the clearing station he can rid himself of anxiety pressures by "talking out" tension with a trained listener who is understanding, sympathetic, and respectful. In this way he can air his fears freely, face up to them, and see them for what they are. Since he is usually in a state of heightened sug-

gestibility, the listener never mentions evacuation or serious illness. On the other hand, he never lets the soldier forget the thought of returning to combat. Usually, a reminder that the other members of his unit are still on the frontline is sufficient to reinforce his sense of duty.

d. Create a Non-Hospital Atmosphere. Since hospitalization suggests a continued illness and encourages an exaggeration of symptoms, the ward atmosphere should be as much like a normal duty situation as possible. Wards housed in tents instead of buildings and ward personnel dressed in fatigues instead of hospital clothing help to create such an atmospshere. Keeping the combat exhaustion casualty involved in light work and exercise suggests to him that he is taking only a brief therapeutic rest and will soon be ready for duty again.

e. Return to Duty as Early as Possible. Getting the soldier back into action as soon as possible not only is an objective in treating combat exhaustion but also is a principle vital to successful treatment. In addition it conserves the time and efforts of medical personnel. The longer the soldier stays at the aid station or any other medical facility, the greater are the chances of his losing group identification and developing secondary symptoms which grow out of waiting, guilt, and self-pity. The sooner the soldier is rehabilitated and returned to duty, the more time the medical personnel will have to treat other casualties.

189. Method, Location, and Period of Treatment

Although the Army psychiatric treatment for the mild, moderate, and severe cases of combat exhaustion follows flexible patterns which are adjusted to individual symptoms, the period and location of treatment are generally as follows:

a. Mild to moderate cases are treated at the battle group aid station for a period of 8 to 24 hours. Sixty percent of these casualties return to combat duty; the remainder are evacuated.

b. Since casualties with moderate and severe combat exhaustion are unable to withstand further stress, they need more physical and emotional protection. They are evacuated, therefore, to the division clearing station where they are treated for their individual disorders. After approximately five days of psychiatric therapy, fifty percent of them are usually able to return to combat duty.

c. Patients who do not respond to therapy at the division clearing station are evacuated to psychiatric facilities farther in the rear. From 10 to 20 percent of these patients return to combat duty. A large number are reassigned to noncombat jobs.

Section VII. RESPONSIBILITIES OF THE SPECIALIST

190. Member of Psychiatric Team

Two neuropsychiatric specialists are among the eight-man psychiatric team at each division clearing station. A psychiatric social worker is directly in charge of the neuropsychiatric section, supervising treatment and administration. Additional professional supervision is given by the division psychiatrist, depending upon his work load. The other personnel in the section are two social work specialists, a clinical psychology specialist, and a records clerk.

191. General Responsibilities

Because of unusually heavy casualties or personnel shortages, the specialist may temporarily be the only team member available to help psychiatric patients. For this reason he often takes on a job that would be handled by more responsible personnel in a clinic or hospital situation. The moment a patient arrives at the division clearing station, which is three to four miles behind the front, the specialist's work begins.

a. He questions the accompanying medical corpsmen to learn whether the patient was calm or agitated in transit. With this information he decides whether physical restraint or seclusion is necessary.

b. To determine the possible degree of stress which the patient has undergone, he finds out the location from which the patient has come and whether or not the activity there was especially heavy.

c. If the patient still has his weapons and equipment, the specialist, for reasons of safety and convenience, relieves him of them.

d. To determine the extent of previous medication, he reads the patient's emergency medical tag.

e. Since the specialist has no way to be certain that the patient has been given a physical examination, he inspects him for wounds, scratches, and abrasions. He also checks and records his temperature and pulse.

f. He listens carefully to the patient's complaints and records them.

g. After acquiring the necessary information about the patient, the specialist provides for his immediate physical needs. He introduces the patient to other men in the ward and tells him what is expected of him. If the patient has not had food recently,

he gives him opportunity to eat. He shows him his bunk and latrine facilities. He encourages him to shower, shave, and change clothes. These "luxuries," which have great reassurance value, are important aids to the therapy that he will receive.

192. The Specialist's Role in Therapy

a. The specialist's role in therapy is that of reassurance, acceptance, and firm redirection to active duty. In the performance of this role, he applies the following principles as discussed in paragraph 188*b*, *c*, and *d*:

(1) Rehabilitate physically.

(2) Provide an opportunity for ventilation.

(3) Create a non-hospital atmosphere.

b. The specialist also has two responsibilities which indirectly affect the success of therapy.

(1) He must constantly evaluate his attitudes in order to keep the relationship with the patient objective. He must not over-identify with or be antagonized by the patient.

(2) He must pass on his knowledge of combat exhaustion to all personnel with whom he comes in contact, since few of them will fully understand the emotional impact of combat.

APPENDIX I
REFERENCES

1. Government Publications

AR 40–2	Army Medical Treatment Facilities—General Administration
AR 40–3	Medical, Dental, and Veterinary Care
AR 40–21	Medical Treatment Facilities
AR 40–22	Organization of Class I United States Army Hospitals
AR 40–216	Neuropsychiatry
AR 40–353	Evacuation of Patients
AR 40–535	Aeromedical Evacuation
AR 320–5	Dictionary of United States Army Terms
AR 320–50	Authorized Abbreviations and Brevity Codes
AR 611–201	Manual of Enlisted Military Occupational Specialties
AR 940–10	National Red Cross Service Program and Army Utilization
SR 40–1025–2	Joint Armed Forces Nomenclature and Method of Recording Psychiatric Conditions
FM 8–10	Medical Service, Theater of Operations
FM 21–5	Military Training
FM 21–6	Techniques of Military Training
FM 21–10	Military Sanitation
FM 21–11	First Aid for Soldiers
FM 21–30	Military Symbols
TM 8–230	Medical Corpsman and Medical Specialist
TM 8–240	Psychiatry in Military Law
TM 8–241	Army Social Work
TM 8–242	Military Clinical Psychology
TM 8–244	Military Psychiatry
TM 8–246	Army Social Work Handbook
TM 8–291	Occupational Therapy
TM 8–292	Physical Reconditioning

DA Pam 8–13	Interpersonal Relations in the Care and Management of Patients
DA Pam 108–1	Index of Army Motion Pictures, Film Strips, Slides, and Phono-Recordings
DA Pam 310-series	Indexes to Military Publications

2. Textbooks and Miscellaneous References

Brown, Martha Montgomery, and Fowler, Grace R. *Psychodynamic.* Second Edition, Philadelphia: W. B. Saunders Company, 1961.

Coleman, James C. *Abnormal Psychology and Modern Life.* Second edition. Chicago: Scott, Foresman and Company, 1956.

Corsini, Raymond J. *Methods of Group Psychotherapy.* New York: Blakiston Division—McGraw-Hill Book Company, Inc., 1957.

Crawford, Annie L., and Buchanan, Barbara B. *Psychiatric Nursing—(A Basic Manual).* Philadelphia: F. A. Davis Company, 1962.

Crawford, Annie L., and Kilander, U. C. *Nursing Manual for Psychiatric Aides.* Philadelphia: F. A. Davis Co., 1954.

de Gutiérrez-Mahoney, C. G., and Carini, Esta. *Neurological and Neurosurgical Nursing.* Third edition. St. Louis: The C. V. Mosby Company, 1960.

English, O. Spurgeon and Finch, J. *Introduction to Psychiatry.* New York: W. W. Norton & Co., 1954.

Ewalt, Jack R., Strecker, Edward A., and Ebaugh, Franklin G. *Practical Clinical Psychiatry.* Eighth Edition, New York: Blakiston Division—McGraw-Hill Book Company, Inc., 1957.

Fitzsimmons, Laura W. *Textbook for Psychiatric Attendants.* New York: The MacMillan Co., 1947.

Gibbs, Frederic A. and Erna L. *Atlas of Electroencephalography. Vols. I and II.* Second edition. Cambridge: Addison-Wesley Press, Inc., 1950 and 1952.

Greenblatt, Milton; Levinson, Daniel J.; and Williams, Richard H., editors. *The Patient and the Mental Hospital.* Glencoe, Illinois: The Free Press, 1957.

Gregory, Ian. *Psychiatry, Biological and Social.* Philadelphia: W. B. Saunders Company, 1961.

Grinker, Roy R., and Spiegel, John P. *Men Under Stress.* New York: Blakiston Division—McGraw-Hill Book Company, Inc., 1945.

Henderson, D. L., and Gillespie, R. D. *Textbook of Psychiatry.* Ninth Edition, New York: Oxford Press, 1962.

Hinsie, Leland E., and Campbell, Robert Jean. *Psychiatric Dictionary.* New York: Oxford University Press, 1960.

Hofling, Charles K., and Leininger, Madeline M., *Basic Psychiatric Concepts in Nursing.* Philadelphia: J. B. Lippincott Company, 1960.

Ingram, Madeline E. *Principles and Techniques of Psychiatric Nursing.* Fifth Edition, Philadelphia: W. B. Saunders Co., 1960.

Kalkman, Marion E. *Introduction to Psychiatric Nursing.* Second edition. New York: McGraw-Hill Book Company, Inc., 1958.

Karnosh, Louis J., and Mereness, Dorthy. *Psychiatry for Nurses.* Fifth edition. St. Louis: The C. V. Mosby Company, 1958.

Kimball, Lenore, *Psychiatric Nursing—Syllabus and Workbook for Student Nurses.* Third edition, St. Louis: C. V. Mosby Company, 1962.

Manfreda, Marguerite L. *Teaching Psychiatric and Mental Health Nursing.* Philadelphia: F. A. Davis Company, 1961.

Matheney, Ruth V., and Topalis, Mary. *Psychiatric Nursing.* Third edition. St. Louis: The C. V. Mosby Company, 1961.

Mereness, Dorthy and Karnosh, Louis J. *Essentials of Psychiatric Nursing.* Sixth edition, St. Louis: C. V. Mosby Company, 1962.

Mezer, Robert R. *Dynamic Psychiatry in Simple Terms.* Second edition. New York: Springer Publishing Company, Inc., 1960.

National Association for Mental Health: *Handbook for Psychiatric Aides,* Sections I & II. National Association for Mental Health, 1790 Broadway, New York, N. Y., 1950.

Noyes, Arthur P., and Kolb, Lawrence C. *Modern Clinical Psychiatry.* Fifth edition. Philadelphia: W. B. Saunders Company, 1958.

Noyes, Arthur P.; Hayden, Edith M.; and van Sickel, Mildred. *Textbook of Psychiatric Nursing.* Fifth edition. New York: The Macmillan Company, 1959.

Odlum, Davis M. Mental Health. *The Nurse and the Patient.* Philadelphia: J. B. Lippincott Company, 1960.

Render, Helena Willis, and Weiss, M. Olga. *Nurse-Patient Relationships in Psychiatry.* Second edition. New York: McGraw-Hill Book Company, Inc., 1959.

Robinson, Alice M. *The Psychiatric Aide.* Second edition. Philadelphia: J. B. Lippincott Company, 1959.

Rodeman, Charlotte R. *A Guide for Psychiatric Aides.* New York: The MacMillan Company, 1956.

Ruch, Floyd L. *Psychology and Life.* Fifth edition. Chicago: Scott, Foresman and Company, 1958.

Saul, Leon J. *Emotional Maturity.* Philadelphia: J. B. Lippincott Company, 1960.

Schwartz, Morris S., and Shackley, Emmy Lanning. *The Nurse and the Mental Patient.* New York: Russell Sage Foundation, 1956.

Steele, Katharine McLean, and Manfreda, Marguerite Lucy. *Psychiatric Nursing.* Sixth edition. Philadelphia: F. A. Davis Company, 1962.

Strecker, Edward A. *Fundamentals of Psychiatry.* Fifth Edition, Philadelphia: J. B. Lippincott Company, 1952.

Wallen, Richard W. *Clinical Psychology—The Study of Persons.* New York: Blakiston Division—McGraw-Hill Book Company, Inc., 1956.

APPENDIX II

CLASSIFICATION OF NEUROPSYCHIATRIC DISORDERS

1. Psychotic Disorders Without Known Organic Etiology

a. Schizophrenic Reactions.

(1) *Schizophrenic reaction, simple type.* A person with this type of reaction is dull and uninteresting. He is satisfied to lead a shiftless, simple life in idle fantasy. He shows little concern over anything or anyone; however at times he may be moody and irritable. As a rule, he is merely considered to be "peculiar." He may work at some simple routine labor, or he may become a tramp or a vagrant.

(2) *Schizophrenic reaction, hebrephrenic type.* This type of reaction usually begins in the period of early adolescence. Early symptoms may be fatigue, irritability, staring, and preoccupation. The individual withdraws from social contact. As the disorder progresses, he becomes very silly. For no apparent reason, he may break into silly laughter. He has visual and auditory hallucinations and very bizarre ideas. He develops peculiar mannerisms which he may repeat continually. He reverts to extremely childish behavior; he soils himself and exhibits an infantile lack of modesty. He may have outbursts of violent anger or obscene behavior.

(3) *Schizophrenic reaction, catatonic type.* This type of reaction usually develops suddenly; it often appears after an emotional shock. It may be manifested in two forms, catatonic stupor and catatonic excitement.

(*a*) *Catatonic stupor.* In this form the person is mute. Most of the time he stares downward with a vacant expression and may drool. He may remain in the same position indefinitely and show no reaction to pin pricks or other such stimuli. His skin appears waxy, and his hands and feet may become swollen and cyanotic from lack of motion. He may retain his bowel and bladder contents or soil himself. He may have to be dressed, undressed, fed, bathed, and given all other personal care.

(*b*) *Catatonic excitement.* In this form the person is the opposite of the stuporous type. He is extremely overactive with no apparent purpose or organization to his activity; his movements seem to be automatic and incoherent. Frequently, he has hallucinations and marked flights of ideas. He may have impulsive and violent outbursts of destructiveness. He may be negativistic: he may refuse to remain clothed and may soil himself.

(4) *Schizophrenic reaction, paranoid type.* Delusions, usually illogical and absurd, are an outstanding symptom in the paranoid type of reaction. Often, the delusions are those of persecution, as the person projects many ideas and attributes of his own to others. The person may have auditory hallucinations and complain of voices that are threatening him. His behavior may be unpredictable; he may be resentful, irritable, or hostile.

(5) *Schizophrenic reaction, latent.* Except under close observation and examination, a person with this reaction may show no actual psychotic symptoms. To his friends and acquaintances, he may appear merely queer and eccentric. He represents the borderline psychosis. He is seldom hospitalized.

(6) *Schizophrenic reaction, not elsewhere classified (n.e.c.).* This term is used to classify both acute and chronic schizophrenic reactions which cannot be appropriately clasified as one of the other types.

(*a*) *Acute.* A person with an acute reaction may suddenly manifest schizophrenic symptoms such as confusion, ideas or reference, fear, and dream states; he may become very excited or very depressed. These symptoms may clear up as suddenly as they appear; they may recur.

(*b*) *Chronic.* The person manifests mixed symptoms which cannot be given a specific classification.

b. Affective Reactions.

(1) *Manic-depressive reaction.* This reaction is characterized by severe mood swings. Usually, the person has psychotic episodes with intervening periods of good mental health. The psychotic episodes may be either the manic or depressive type.

(*a*) *Manic type.* This type is characterized by increased activity in all phases of the personality. The person is very happy, gay, overtalkative, overactive, distracti-

ble, and mischievous. Ideas seem to come to the person so fast that he cannot express them to completion but jumps from one to another. He is tireless; he requires little sleep.

(*b*) *Depressed type.* This type is the exact opposite of the manic type. The person is retarded or slowed down in all phases of his personality. He has severe feelings of unworthiness, guilt, and remorse. His facial expression is one of hopelessness, and his overall appearance is one of complete dejection. Any act, even routine personal hygiene, seems to require too much effort to perform. He has a poor appetite. He is suicidal. The depression may be so severe that he is stuporous.

(2) *Psychotic depressive reaction.* This reaction differs from the manic-depressive reaction in that the person has no history of previous attacks and misinterprets everything in his environment in terms of his own guilt or unworthiness. He presents much the same physical appearance as the manic-depressive, depressed type.

(3) *Involutional melancholia.* This reaction occurs in the middle or later years of life. Usually, there is no history of manic or depressive illnesses. This reaction is characterized most commonly by depression. It is manifested with and without agitation and by worry, guilt, anxiety, paranoid delusions, and often gastrointestinal and other bodily complaints. The person has strong suicidal tendencies.

c. Paranoid Reactions. These reactions are manifested primarily by delusions of persecution or grandeur.

(1) *Paranoia.* This type of reaction is rare. It is characterized mainly by a fixed logical system of delusions. The general behavior does not change except as influenced by the delusions. The person believes he has special talents and abilities and considers himself to be far superior to others.

(2) *Paranoid state.* This type of reaction is characterized by paranoid delusions. It lacks the systematization seen in paranoia, yet it does not manifest the bizarre fragmentation and deterioration of the schizophrenic. It occurs most frequently in individuals between 35 and 55 years of age. Ordinarily, the duration of this reaction is relatively short, though it may be persistent and chronic.

2. **Psychoneurotic Disorders** (Synonymous with the term *neurotic disorders*)

a. Anxiety Reaction. This is the simplest and most frequent type of neurotic reaction. It is characterized by anxious expectation and frequently associated with bodily symptoms such as palpitation of heart, sweating, and shortness of breath. The anxiety is diffused and not restricted to any particular situation or object. The condition is to be differentiated from normal apprehensiveness and fear.

b. Dissociative Reaction. This reaction is characterized by overwhelming anxiety, resulting in aimless running or "freezing" as often seen in combat situations. In some cases the anxiety is deflected into various symptoms such as multiple personality and amnesia (loss of memory).

c. Conversion Reaction. A reaction of this type is characterized by the conversion of anxiety into organs or parts of the body under voluntary control. Symptoms typically seen are anesthesia (loss of sensation in a limb), monoplegia (paralysis of one limb), hemiplegia (paralysis of one-half of body), blindness, and deafness. The symptoms, symbolic of the underlying mental conflict, serve to lessen the feelings of anxiety and to produce secondary gain, thereby meeting the needs of the patient.

d. Phobic Reaction. In this reaction the anxiety is detached from the difficult life situation by an unconscious mechanism and displaced to some symbolic idea such as a specific fear. The phobic object or situation may be dirt, heights, closed spaces, animals, et cetera. A person in the military often fears specific weapons, planes, and combat noises. A person with a phobic reaction attempts to control his anxiety by avoiding the phobic object or situation.

e. Obsessive-Compulsive Reaction. In this reaction the anxiety is associated with the persistence of unwanted ideas and repetitive impulses to perform certain acts. The individual may regard his ideas and behavior as unreasonable and even silly; nevertheless he feels compelled to carry out the acts or rituals. Specific symptoms such as repetitive handwashing, touching, and recurring thoughts are most usual.

f. Neurotic Depressive Reaction. In this reaction the anxiety brought on by some loss is allayed or relieved by depression, sadness, and self-depreciation. The reaction is often associated with feelings of guilt for past failures or deeds. This reaction is less severe than the psychotic depression reaction.

g. Somatization Reaction. Anxiety expressed by way of body organs controlled by involuntary nervous system is characteristic of this reaction. The symptoms such as anorexia (loss of appetite) and hypertension (high blood pressure) are due to a chronic and exaggerated state of the normal physiology of anxiety or other emotions as anger and sadness. Long continued visceral dysfunction may eventually cause structural changes such as duodenal ulcer, ulcerative colitis, asthma, and hypertension.

h. Hypochondriacal Reaction. This reaction is characterized by the individual's obsessive concern about his state of health or condition of his body. The individual often has multiple complaints about different organs or body systems.

3. Character and Behavior Disorders

a. Pathological Personality Types. This classification applies to individuals whose personality maladjustment is evidenced in lifelong abnormal behavioral patterns. Because of the severity and depth of psychopathology the behavioral patterns can rarely be altered by any form of therapy. Under conditions of stress these states may become exaggerated and disabling; occasionally, they progress to psychoses.

(1) *Schizoid personality.* The person reacts with unsociability, seclusiveness, serious mindedness, and nomadism, and often with eccentricity.

(2) *Paranoid personality.* The individual has many traits of the schizoid personality and a conspicuous tendency to utilize a projection mechanism, expressed by suspiciousness, envy, extreme jealousy, and stubbornness.

(3) *Cyclothymic personality.* The person frequently has alternating moods of elation and sadness, stimulated apparently by internal factors rather than by external events. He may occasionally be either persistently euphoric or depressed without falsifying or distorting reality.

(4) *Inadequate personality.* The person responds inadequately to intellectual, emotional, social, and physical demands. On examination he is not grossly deficient physically or mentally but shows inadaptability, ineptness, poor judgment, and social incompatibility.

(5) *Antisocial personality.* The individual is chronically antisocial and is always in trouble, profiting neither from experience nor punishment and maintaining no real loyalties to any person, group, or code. He is frequently callous, impulsive, and emotionally immature.

He lives for his own pleasures, acts out internal conflicts, shows poor judgment, lacks a sense of responsibility, and has an unusual power of rationalization, making his behavior appear warranted and reasonable.

(6) *Sexual deviate.* The person has no obvious psychotic or neurotic symptoms, but his behavior includes abnormalities such as homosexuality and sexual assault.

b. Immaturity Reactions. This classification applies to individuals who are unable to maintain their emotional equilibrium and independence under major or minor stress because of deficiencies in emotional development. Neurotic features are relatively insignificant. The basic personality maldevelopment, rather than overt anxiety, is the crucial factor.

(1) *Emotional instability reaction.* The individual reacts with excitability and ineffectiveness when he is confronted with minor stress. His relationship to other people is continuously fraught with fluctuating emotional attitudes because of his strong and poorly controlled hostility, guilt, and anxiety.

(2) *Passive-dependency reaction.* The person has the characteristics of helplessness and indecisiveness and a tendency to cling to others. The child-parent relationship is predominant. The clinical picture of the person is often associated with an anxiety reaction.

(3) *Passive-aggressive reaction.* The person expresses aggressiveness by such passive measures as pouting, stubbornness, procrastination, inefficiency, and passive obstructionism.

(4) *Aggressive reaction.* The individual persistently reacts to frustration with irritability, temper tantrums, and destructive behavior. A specific variety of this reaction is a morbid or pathological resentment. Below the surface, a deep dependency is usually evident.

(5) *Immaturity with symptomatic "habit" reaction.* The person has certain specific symptoms such as enuresis, speech disorder, stammering, stuttering, and excessive masturbation but has no other obvious symptom of neurosis, psychosis, or organic conditions.

c. Alcoholism. This term is used to classify severe character disturbances in which there is well-established addiction to alcohol without a recognizable underlying disorder. Alcoholism, however, can be symptomatic of any psychiatric disorder. Simple drunkenness and acute poisoning from alcohol are not included in this category.

d. Addiction. Drug addiction is usually symptomatic of a personality disorder; however it, like alcoholism, can be symtomatic of any psychiatric disorder. Frequently, an individual under the influence of a drug engages in antisocial behavior such as fighting and stealing.

e. Primary Childhood Behavior Reactions. This term applies to a large group of childhood problems which are expressions of serious emotional difficulties not due to organic defects. Any individual with this reaction has such symptoms as night terrors, anxiety attacks, phobias, stealing, lying, bed-wetting, et cetera.

4. Psychiatric Disorders with Demonstrable Physical Etiology or Associated Structural Changes in the Brain (Synonymous with the term *organic behavior disorders*)

a. Psychotic Reactions. These reactions are associated with physical disease or condition. They may manifest any of the psychotic symptoms of the schizophrenic, affective, or paranoid reactions along with the symptoms of the pertinent physical disease or condition.

b. Nonpsychotic Mental Reactions. These reactions do not manifest any of the psychotic symptoms but may resemble one of the psychoneurotic or character and behavior disorders. The person may show only slight confusion, memory defect, irritability, and other similar symptoms.

5. Transient Personality Disorders Due to Acute or Special Stress

a. Combat Exhaustion. This is a personality reaction usually of more or less "normal" persons who have experienced intolerable stress in a situation such as a disaster or combat. Although this reaction may progress to a more severe neurotic or psychotic reaction, it is usually transient when promptly and adequately treated.

b. Acute Situational Maladjustment. Primarily, this reaction is one of superficial maladjustment to acute changes in environmental situations and with no evidence of serious longstanding personality defects or chronic neurotic patterns. Symptoms may be anxiety, alcoholism, inefficiency, low morale, and so forth. If this reaction is not treated or relieved, it may grow into a more serious neurotic or character disorder.

GLOSSARY

Abusive—Inclined to mistreat others or to use insulting language.

Acting out—Expressing through action unconscious emotional conflicts or feelings.

Addiction—The state of being emotionally and physiologically dependent upon alcohol or a drug.

Adjustment—The relationship between an individual and his environment.

Affect—Feeling tone, mood, or emotion.

Aggression—Action carried out in a forceful way in response to a feeling of stress.

Agitation—Restlessness shown by excess motor activity.

Alcoholism—The habitual use of alcohol to the extent that it interferes with one's living.

Ambivalence—Opposing emotions, such as love and hate, for the same person, thing, or event at the same time.

Amnesia—Loss of memory. This usually refers to the inability to remember events which occurred during a specific period of time.

Anxiety—A complex emotional state of tension or uneasiness, the cause of which is not recognized.

Apathy—Markedly decreased emotional feeling.

Apprehension—Dread of expected events, either real or imaginary.

Arteriosclerosis—Hardening of the walls of the arteries. Cerebral arteriosclerosis is a hardening of the walls of the arteries of the brain.

Aura—A sensation such as flashes or spots of light, unusual odors, or numbness which may be experienced by an individual prior to an epileptic or migraine attack.

Autistic thinking—A form of thinking by which one attempts to satisfy unfulfilled desires through intensive imaginary gratification without regard for reality.

Belligerent—Quarrelsome; inclined to fight.

Blocking—An interruption in the train of thought or speech caused by painful emotions.

Central nervous system—The brain and spinal cord.

Cerebral—Pertaining or relating to the brain.

Character—The relatively fixed personality traits of an individual.

Character disorder—Unhealthy behavior patterns and emotional responses which are, in various degrees, socially unacceptable. There is minimal evidence of anxiety.

Circumstantiality—A type of speech in which unnecessary and irrelevant detail is given before the original idea is expressed.

Claustrophobia—Morbid dread of being in a confined or closed place.

Clonus—Muscular spasm with alternating contraction and relaxation.

Coma—A state of profound unconsciousness.

Combat exhaustion—Disabling physical and emotional fatigue which occurs in military combat.

Combative—Inclined to fight.

Compensation—The development of a special ability or trait to make up for an inadequacy which may be real or imaginary; a defense mechanism.

Compulsion—An irresistible urge to perform apparently meaningless actions. *Example:* the urge to step on each crack in the sidewalk.

Concussion—A condition resulting from direct physical injury to the brain, causing temporary symptoms such as confusion or unconsciousness.

Confabulation—Relating imaginary events as being true in order to fill memory gaps.

Conflict—A state of indecision that arises when an individual is confronted by alternatives of action or by contradictory ideas or ideals.

Confused—Bewildered; unable to think clearly.

Congenital—Existing at or before birth.

Conscience—The moral and ethical attitudes which influence behavior. (See *superego.*)

Conscious—Consisting of that of which the individual is aware at a particular time.

Cortex—The outer layer of a body organ such as the brain.

Cyanosis—Blueness of the skin caused by an insufficient amount of oxygen in the blood.

Daydreaming—(See *fantasy.*)

Defense mechanism—An unconscious device or adjustment pattern which the individual uses in attempting to maintain his self-respect, prestige, or security when these are threatened by inner impulses or external forces. Examples of these mechanisms are rationalization, displacement, identification, et cetera.

Delirum—Temporary mental disturbance with confusion and often with hallucinations and excitement.

Delusion—A false belief; an idea without basis or in direct conflict with evidence.

Denial—Refusal to recognize anxiety arousing facts and feelings; a defense mechanism.

Dependency—Reliance on others for advice, guidance, support, et cetera.

Depersonalization—Loss of identity; feelings of unreality or strangeness about the self or the environment.

Depression—A persistent feeling of sadness often accompanied by feelings of hopelessness, inadequacy, and unworthiness and a slowing down of mental and physical activities. (In agitated depression physical activity increases rather than decreases.)

Deterioration—An impairment of the emotional and higher mental processes of the individual.

Disorientation—Inability to place oneself as to time, place, or person.

Displacement—A defense mechanism by which the individual transfers an emotion that he has about a person or object to a different person or object.

Distractible—Attention very easily drawn away from its focus by external stimuli.

Drive—An inner stimulus which arouses the individual to activity in a specific direction.

Dynamics—Activating forces which underlie the development of behavior patterns and emotional reactions.

Ego—That part of the personality which possesses consciousness, maintains identity, and recognizes and tests reality (a psychoanalytic concept of *self*).

Elation—Intensified feeling of well-being and joy.

Electroconvulsive therapy (ECT)—Treatment in which unconsciousness accompanied by a generalized convulsion is produced by transmitting electrical current to the patient's cerebral cortex through electrodes placed on his temples.

Electroencephalogram (EEG)—A graphic recording of the electrical impulses arising from the activity of cells in the cortex of the brain.

Electroshock therapy (EST)— Treatment of disease by means of electricity. (See *electroconvulsive therapy.*)

Emotion—A specific feeling such as that of fear, anger, disgust, grief, joy, love, surprise, yearning, et cetera.

Emotional insulation—A defense mechanism by which the individual avoids frustration and disappointment by withdrawing or adopting a passive attitude.

Empathy—The ability to understand and share the feelings of another person.

Epilepsy—A condition characterized by periodic impairment of consciousness.

Etiology—The cause(s) of a disease personality maladjustment.

Euphoria—Exaggerated sense of well-being not warranted by circumstances or conditions.

Exhibitionism—Conduct or display of the body for the conscious or unconscious purpose of attracting attention or of experiencing sexual pleasure or excitement.

Extrovert—A person whose interest is turned from the self toward the external environment.

Fabrication—Relating imaginary events as true.

Fantasy—An ego defense mechanism by which the individual gratifies his desires through imaginary events.

Fear—An emotional response to an actual, present danger that threatens from without.

Feeblemindedness—A mental disorder characterized mainly by a defect in intelligence from birth or an early age.

Fixation—Arrest of emotional development at some childhood or adolescent level.

Flight of ideas—A rapid succession of ideas which are related only superficially.

Free-floating anxiety—Chronic reaction pattern in which generalized anxiety is felt in all situations.

Frustration—The thwarting of goals or needs.

Functional disorder—A disorder of emotional origin without known alternation or physical change in body tissue.

Grand mal—A severe epileptic attack with convulsions and unconsciousness.

Group therapy—Psychotherapy through group participation.

Hallucination—A false sensory perception occurring without external stimulus. (It may occur in any of the five senses.)

a. Auditory hallucination—hearing a sound when no noise is present.

b. Visual hallucination—seeing something when nothing is there.

c. Olfactory hallucination—smelling something which is not present and no odor is present to suggest it.

d. Gustatory hallucination—tasting something which is not present and nothing is present to suggest the taste.

e. Tactile hallucination—feeling something which is not really occurring, such as something touching the skin.

Heredity—All of the physical and mental characteristics transmitted from parents to children.

Heterosexual—Sexual interest in a person of the opposite sex.

Homicidal—Inclined toward killing another human being.

Homosexual—Sexual interest in a person of the same sex.

Hostile—Feeling or showing ill-will; unfriendly.

Hyperactive—Abnormally overactive.

Hypnosis—An artificially induced trance-like condition in which the subject is extremely receptive to suggestion.

Hypochondriasis—A morbid concern about one's health and a belief that disease is present even when none can be found; a tendency to exaggerate minor illnesses.

Id—The unconscious part of the personality which contains the primitive instinctual impulses and urges and which is characterized by an unrestrained drive to seek pleasure.

Identification—A defense mechanism by which the individual attempts unconsciously to pattern himself after persons whom he admires in order to become like them. (When an individual consciously patterns himself after others, he is imitating them.)

Illusion—The misinterpretation of a real sensory image.

Impotence—Inability of the male to perform the normal sexual act.

Impulsive—Subject to sudden changes of behavior that cannot be predicted.

Incoherent—Rambling conversation, marked by ideas that are not related.

Inferiority complex—An emotional state characterized by strong feelings of incompetency and unworthiness and by lack of self-confidence.

Inhibition—Restraint or control of a desire.

Insanity—A legal term referring to a mental disorder which causes an individual to be unable to distinguish right from wrong. He cannot, therefore, be held legally responsible for his actions.

Insight—In psychiatry this means the ability of a patient to realize the nature and extent of his illness.

Insomnia—Inability to sleep; abnormal wakefulness.

Introvert—A person who is principally preoccupied or concerned with his own thoughts, feelings, and experiences.

Isolation—A defense mechanism by which the individual avoids feelings of distress by separating thoughts from feelings.

Lability—Instability; rapid changes in emotional states.

Latent—Hidden; inactive.

Lethargy—Slowness of thoughts or movements.

Maladjustment—Inability to adapt one's behavior satisfactory to the conditions of the environment.

Malinger—To pretend illness, consciously and for a reason.

Manic—Having exaggerated feelings of gaiety and well-being, flight of ideas, and physical overactivity.

Mannerism—A gesture or other form of expression peculiar to a given individual.

Masturbation—Self-stimulation of the genitals.

Mechanism—(See *defense mechanism.*)

Melancholia—A morbid emotional state characterized by depression.

Mental hygiene—The investigation and systematic practice of measures for the preservation of mental and emotional health.

Migraine—A psychosomatic condition characterized by periodic headaches, which are often accompanied by nausea, vomiting, and various sensory disturbances.

Mutism—Inability or lack of desire to speak due to emotional causes.

Narcissism—Love of self.

Negativism—Direct opposition or resistance to cooperation.

Nervous breakdown—A term used by laymen to refer to an emotional illness.

Neurology—The branch of medical science devoted to the anatomy, physiology, and pathology of the nervous system.

Neuropsychiatry—The branch of medical science which deals with both neurology and psychiatry.

Neurosis (*Psychoneurosis*)—A funtional disorder in which there is no gross disorganization of personality or loss of contact with reality.

Neurotic—One suffering from a neurosis; pertaining to or affected with a neurosis.

Objectivity—Dealing with problems and difficulties without emotional bias or prejudice.

Obscenity—Using indecent language or engaging in indecent acts.

Obsession—An idea that persists in the mind of an individual, is uninfluenced by logic or reasoning, and cannot be voluntarily dismissed.

Organic—Pertaining to an organ or the organs; structural.

Organic psychosis—A psychiatric illness caused by brain tissue damage or disease. An example is psychosis due to brain tumor.

Orientation—Ability to comprehend and to adjust oneself in an environment with regard to time, place, and identity of persons.

Panic—An attack of acute, overwhelming anxiety accompanied by personality disorganization.

Paranoid—Having delusions or strong feelings of persecution or grandeur by utilizing the mechanism of projection.

Passivity—A trait of character in which conflict is habitually resolved by acceptance rather than opposition, by inaction rather than aggression, and by dependency rather than self-reliance.

Pathology—That branch of medicine which deals with the structural and functional changes caused by disease.

Personality—The integrated organization of all the mental, emotional, and physical characteristics of the individual in relationship to his environment.

Persuasion—An approach based on direct suggestion and guidance and used for the purpose of changing a patient's attitudes, behavior, and goals.

Petit mal—Mild epileptic attack with momentary loss of consciousness but without a convulsion.

Phobia—A fixed morbid fear of an object or a situation.

Prejudice—An attitude for or against persons, objects, or ideas which prevents one from evaluating other points of view; preconceived judgment or opinion.

Prognosis—A forecast as to the probable course and end result of a disease or disorder.

Projection—A defense mechanism by which one attributes to others the unacceptable feelings, attitudes, or motives that are really his own.

Psychiatry—That branch of medicine which deals with mental and emotional disorders.

Psychic—Pertaining to the mind.

Psychoanalysis—A system of psychology, originated by Freud, which attributes behavior to repressed factors in the unconscious.

Psychogenic disorder—(See *functional disorder.*)

Psychology—The science of human behavior, both normal and abnormal.

Psychomotor—Refers to muscular movement of psychological origin.

Psychoneurosis—(See *neurosis.*)

Psychosis—Major mental disorders; extensive disorganization of the personality and loss of contact with reality.

Psychosomatic—Physical illness involving tissue change resulting from sustained emotional tension.

Psychosurgery—Brain surgery performed in the treatment of mental disorders.

Psychotherapy—The treatment of mental illness by psychological methods.

Psychotic—Pertaining to or caused by psychosis.

Rapport—A relationship of harmony and accord between persons.

Rationalization—A defense mechanism by which the individual gives socially acceptable reasons as justifications for his behavior in order to preserve social approval and self-esteem.

Reaction formation—A defense mechanism by which one prevents the expression of unacceptable tendencies by developing behavior patterns that are the exact opposite.

Reactive depression—A depression which results from a specific traumatic experience. (See *depression.*)

Regression—A defense mechanism by which the individual attempts to solve his problems by reverting to behavior which was appropriate at a less mature level of development.

Rejection—A feeling or condition of being unwanted, unloved, ignored, or disowned.

Remission—Temporary disappearance of symptoms; implies that the symptoms may recur.

Repression—A defense mechanism by which the individual excludes painful thoughts or desires from his consciousness without being aware of doing so.

Resistive—Inclined to oppose; offering opposition; refusing to comply or agree.

Retardation—A slowing of all body functions, both mental and physical.

Schizophrenia—A psychotic disorder characterized by disorientation, loss of contact with reality, disorganized patterns of thinking and feeling, and inappropriate affect.

Seclusive—Remaining apart; tendency to withdraw from social contacts.

Sedative—Tending to calm; quieting.

Senile—Pertaining to growing old or to the aged.

Siblings—Children of the same parents.

Sibling rivalry—Competitive and hostile feelings between brothers and sisters for the affection of the parents and for domination over each other.

Somatic—Pertaining to the body.

Sterotyped—Conforming to a fixed pattern; behavior always performed substantially in the same manner.

Stimulus—Anything that causes the individual to react or that is capable of making him react.

Stupor—Partial or nearly complete unconsciousness; a state of reduced responsiveness.

Subconscious—Below the threshold of awareness; can be brought into consciousness with minimal effort.

Subjective—Interpretation based on personal opinion rather than objective observation.

Sublimation—A defense mechanism by which a socially approved activity is substituted for drives or needs which cannot be gratified through natural expression.

Substitution—A defense mechanism by which the individual evades possible failure or lessens the effect of actual failure in overcoming an obstacle by selecting a different goal, usually an easier one.

Superego—That part of the mind which acts as a monitor over the ego; that part of the personality which functions as the conscience.

Suppression—Rejecting undesirable thoughts, wishes, or memories through conscious effort.

Sympathism—A defense mechanism by which the individual supports his feelings of self-esteem by obtaining sympathy from others.

Syndrome—A group of symptoms which characteristically occur together.

Tension—A feeling of strain and uneasiness.

Therapeutic—Pertaining to treatment.

Therapy—Treatment directed toward the cure, alleviation, or prevention of disease.

Toxic—Pertaining to poison; poisonous.

Tranquilizer—A drug which reduces anxiety without clouding consciousness.

Traumatic—Of, pertaining to, or caused by an injury, either physical or psychological.

Tremor—An involuntary trembling or quivering.

Unconscious—That part of the mind which is not directly accessible to conscious awareness.

Undoing—A defense mechanism which involves making amends or atonement to relieve guilt feelings and to maintain self-esteem.

Untidy—This term, when applied to the psychiatric patient, means that he has soiled himself with his body discharges.

INDEX

	Paragraph	Page
ABC of observing and reporting	68	37
Acting out	40	15
Activities, therapeutic	74–76	44, 45
Addiction, alcohol and drug	125–130, app. II	83–86, 132
Admission of patient	96–100	66–69
Affective reactions	95*a*(2), app. II	64, 132
Aggression	92	60
Air travel, preparation for	144	95
Alcoholics Anonymous	127*b*	85
Antisocial behavior	122	81
Anxiety:		
As motivator of behavior	101–106	70, 71
Defenses	25–41, 106, 183–184	11, 15, 71, 120, 121
Definition	24, 102	11, 70
Assaultive behavior	92–93	60
Attitude, importance	52	25
Behavior:		
Aggressive	92	60
Antisocial	122–124	81–83
Assaultive	92–93	60
Emotional crutch, use of	125–130	83–86
Meaning of	56	30
Overactive	119–121	79–80
Physical symptoms, expressed by	107–109	72, 73
Projective	113–115	75, 76
Ritualistic	110–112	73, 74
Understanding of	55–56	29, 30
Withdrawn	116–118	77, 78
Chaplain	46*h*	20
Character and behavior disorders	95*d*, app. II	65, 132
Chemotherapy	159–162	104–107
Combat exhaustion	175–192, app. II	116–127, 132
Communication:		
Facilities	73	42
Factors influencing	58	31
Means of	59	32
With patient	57–60	31–33
Compensation	29	12
Concepts:		
Psychiatric team	62	34

	Paragraph	Page
Concepts—Continued		
Therapeutic environment	70	40
Underlying human behavior	3	3
Defense mechanisms (*See* Ego defense mechanisms.)		
Delirium tremens	126*a*(1)	84
Denial of reality	27	12
Discharge of patient	142–146	94–97
Disciplinary barracks	48	22
Disorders:		
Character and behavior	95*d*, app. II	65, 132
Neurotic	95*b*, app. II	64, 132
Organic behavior	95*e*, app. II	65, 132
Psychiatric	94–95, app. II	63, 132
Psychoneurotic (*See also* Neurotic.)	app. II	132
Psychosomatic	95*c*, app. II	65, 132
Psychotic	95*a*, app. II	64, 132
Transient personality	95*f*, app. II	65, 132
Displacement	33	13
Drugs:		
Addiction	125–130	83–86
Administration	84*b*(5)	52
Therapeutic use	159–163	104–107
Duties:		
Chaplain	46*h*	20
Nurse	46*b*	19
Occupational therapist	46*f*	20
Personnel, auxiliary	46*i*	20
Psychiatrist	46*a*	18
Psychologist, clinical	46*d*	19
Recreator, Red Cross	46*g*(1)	20
Social worker, clinical	46*e*	19
Social worker, Red Cross	46*g*(2)	20
Specialist	46*c*	19
Ego:		
Defense mechanisms:		
Constructive use	25–41	11–15
Pathological use	106	71
Definition	22	10
Electroconvulsive therapy	163–167	108–111
Electroencephalogram	155–158	103, 104
Elemination, bowel and bladder	78*h*	47
Emergency care	89	57
Emotional crutch	125	83
Emotional insulation	35	14
Environment, therapeutic:		
Basic aspects	72–73	41, 42
Characteristics	71	40
Control of hazards	83–84	51
Nutrition	79–82	48–50
Physical care	77–78	45, 46
Prevention and management assaultive behavior	92–93	60

	Paragraph	Page
Environment, therapeutic—Continued		
Prevention of escape	90–91	58, 59
Prevention of suicide	85–89	54–57
Therapeutic activities	74–76	44, 45
Epilepsy	136–141	90–93
Equipment:		
Electroconvulsive therapy	164	109
Lumbar puncture	150*b*, 154	101–103
Sodium amytal interview	162*b*(2)	108
Escape	90–91	58, 59
Evacuation of patients, fire	84*e*	53
Examination, psychiatric	147–148	100
Fantasy	28	12
Fire, prevention and control	84*e*	53
Food:		
Patient's refusal	80	48
Socializing factor	81	50
Specialist's role	82	50
Haircuts	78*e*	46
Hazards	83–84	51
Health, mental	4	5
Hospital:		
Environment, therapeutic	70–76	40–45
Services	45	17
Id	21	10
Identification:		
Defense mechanism	26	12
Tags for air travel	144*b*(3)–(5)	96, 97
Illness, mental	5	5
Incontinence	78*i*	47
Injuries, emergency care for	89	57
Insulin therapy	168–170	112
Involutional melancholia	app. II	132
Isolation (defense mechanism)	36	14
Keys, management of	84*a*	51
Korsakoff's psychosis	126*a*(2)	84
Listening, importance of	60	33
Lost articles, recovery of	84*c*	53
Lumbar puncture	149–154	100–103
Mail	73*a*	42
Maturity	43	17
Mental:		
Health	4	5
Illness	5	5
Mental Hygiene Consultation Service	47	21
Myelogram	152*b*	102
Nail care	78*g*	47
Neuropsychiatric disorders (*See* Disorders, psychiatric.)		
Neurotic disorders	95*b*, app. II	64, 132

	Paragraph	Page
Nurse	46*b*	19
Nursing care:		
Admission, upon	96–100	66–69
Chemotherapy	159–162	104–107
Discharge, preparation for	142–146	94–97
Disease and injury	78*a*	46
Electroconvulsive therapy	163–167	108–111
Electroencephalogram	155–158	103, 104
Emergency	89	57
Insulin therapy	168–170	112
Lumbar puncture	149–154	100–103
Patients with:		
Addiction	125–130	83–86
Aggressive behavior	92–93	60
Antisocial behavior	122–124	81–83
Combat exhaustion	175–192	116–127
Epilepsy	136–141	90–93
Organic brain disorder	131–135	87–89
Overactive behavior	119–121	79, 80
Physical symptoms	78, 107–109	46, 72, 73
Projective behavior	113–115	75, 76
Ritualistic behavior	110–112	73, 74
Withdrawn behavior	116–118	77, 78
Physical	77–78	45, 46
Psychiatric examination	147–148	100
Psychotherapy	171–174	113–115
Nutrition	79–82	48–50
Observing	67–68, 98	37, 68
Occupational therapy:		
Activities	74–76	44, 45
Therapist	46*f*	20
Oral Hygiene	78*b*	46
Organic behavior disorders	95*e*, app. II	65, 132
Organic brain disorder	131–135	87–89
Overactivity	119	79
Patients (*See* Nursing care.)		
Patterns of adjustment (*See* Ego defense mechanisms.)		
Personality:		
Criteria of maturity	43	15
Definition	7	6
Developmental tasks	13–19	8–10
Dynamics	20–24	10, 11
Ego defense mechanisms	25–41	11–15
Factors underlying development:		
Environment	10	7
Heredity	9	7
Interaction	11	7
Learning	12	7
Pathological	app. II	132
Physical care	77–78	45, 46

	Paragraph	Page
Physical symptoms	78, 107	46, 72
Pneumoencephalogram	152*a*	102
Procedures (*See* Nursing care.)		
Prognosis:		
Addiction to alcohol or drug	128	85
Epilepsy	139	93
Organic brain disorder:		
Acute	133*a*	89
Chronic	133*b*	89
Projection	34, 113	14, 75
Property of patient	100	69
Psychiatric casualty, combat	175–192	116–127
Psychiatric disorders	94–95, app. II	63, 132
Psychiatrist	46*a*	18
Psychologist, clinical	46*d*	19
Psychosomatic disorders	95*c*, app. II	65, 132
Psychotherapy	171–174	113–115
Psychotic disorders	95*a*, app.II	64, 132
Purpose (of manual)	1	3
Rationalization	30	12
Reaction formation	32	13
Red Cross:		
Activities	74–76	44, 45
Recreator	46*g*(1)	20
Social worker	46*g*(2)	20
References	App. I	128
Regression	37	14
Relationships:		
Specialist-patient	51–54	24–26
Team members	64	35
Reporting	67–69, 98	37–39, 68
Repression	31	13
Restraint	93*c*(2), 146	62, 97
Ritualistic behavior	110	73
Role of specialist pertaining to:		
Admission care	97	66
Aggressive behavior (*See* Assaultive behavior.)		
Antisocial behavior	124	83
Assaultive behavior	93	60
Chemotherapy	160*e*, 161*b*, 162*b*(2)	106, 107
Combat exhaustion	190–192	126, 127
Communication with patient	57–60	31–33
Discharge of patient	143	94
Electroconvulsive therapy	165–167	110, 111
Electroencephalogram	156–158	103, 104
Emergency care	89	57
Emotional crutch, use of	130	86
Epilepsy	141	93
Escape	91	59
Examination, psychiatric	148	100
Feeding patients	82	50

	Paragraph	Page
Role of specialist pertaining to—Continued		
Fire prevention and control	84*e*	53
Hazards	84	51
Lumbar puncture	150–154	100–103
Observing and reporting	67–69, 98	37–39, 68
Organic brain disorder	135	89
Overactive patient	121	80
Physical care	77–78	45, 46
Physical symptoms	78, 109	46, 73
Projective behavior	115	76
Psychotherapy	174	115
Relationships, therapeutic	51–54	24–26
Ritualistic behavior	112	74
Suicide, prevention of	88	56
Team relations	61–66	34–36
Therapeutic activities	76	45
Understanding patients behavior	55–56	29, 30
Withdrawn patient	118	78
Schizophrenic reactions	95*a* (1), app. II	64, 132
Sedatives	162	107
Seizures, epileptic	137	90
Services, psychiatric:		
Combat	187–192	124–127
Disciplinary Barracks	48	22
Hospital	45–46	17
Mental Hygiene Consultation Service	47	21
Purpose, general	44	17
Shampoos	78*f*	46
Shaving	78*d*	46
Showering	78*c*	46
Sleep and rest	78*j*	47
Social worker:		
Clinical	46*e*	19
Red Cross	46*g* (2)	20
Sodium amytal interview	162*b*	107
Specialist, psychiatric:		
Duties	46*c*	19
Importance of	49	23
Role (*See also* Role of specialist.)	49–69	23–39
Skills	50	23
Team member	66	36
Spinal tap	149–154	100–103
Stimulants	161	107
Sublimation	39	15
Suicide	85–89	54–57
Superego	23	11
Sympathism	41	15
Team, psychiatric:		
Approach	63	34
Concept	62	34
Members	46	17

	Paragraph	Page
Team, psychiatric—Continued		
Planning	65	36
Relationships	61–66	34–36
Specialist's responsibilities	66	36
Telephone calls	73*c*	43
Therapy:		
Activities, therapeutic	75	44
Electroconvulsive	163–167	108–111
For addiction to alcohol or drug	127	84
For epilepsy	138	93
For organic brain disorder:		
Acute	132*a*	88
Chronic	132*b*	88
Insulin	168–170	112
Occupational	74–76	44, 45
Psychotherapy	171–174	113–115
Tranquilizers	160	104
Transfer, admission by	99	68
Transient personality disorders	95*f*, app. II	65, 132
Travel, physical preparation for	143*c*–146	95–97
Understanding:		
Patient's behavior	55	29
Self-understanding, importance of	53	25
Undoing	38	14
Visitors	73*b*	43
Wards, psychiatric	72	41
Withdrawal	116	77

BY ORDER OF THE SECRETARY OF THE ARMY:

G. H. DECKER,
General, United States Army,
Chief of Staff.

Official:

J. C. LAMBERT,
Major General, United States Army,
The Adjutant General.

Distribution:

Active Army:

DCSPER (1)	USA Corps (2)
ACSI (1)	Div (2)
DCSOPS (2)	Bde (1)
ACSRC (2)	Regt/Gp/BG (1) except
CARROTC (1)	Med Gp (3)
TIG (1)	Med Bn (3)
CMH (1)	Med Co (3)
CNGB (1)	Svc Colleges (2)
TSG (50)	Br Svc Sch (2) except
USCONARC (5)	MFSS (100)
ARADCOM (2)	USA Med Tng Cen (5)
ARADCOM Rgn (1)	WRAMC (5)
OS Maj Comd (2)	Gen Hosp (5)
OS Base Comd (1)	Army Hosp (2)
LOGCOMD (1)	USA Hosp (2)
MDW (3)	Disp (1)
Armies (3)	Units org under fol TOE:
Corps (2)	8–500 KO (15)

NG: State AG (3); units same as active Army except allowance is one copy to each unit.

USAR: Same as active Army except allowance is one copy to each unit.

For explanation of abbreviations used, see AR 320–50.

U. S. GOVERNMENT PRINTING OFFICE: 1962—650514

UNIVERSITY OF MICHIGAN
3 9015 04560 2326